COUNTY OF KERN

KERN BEHAVIORAL HEALTH & RECOVERY SERVICES

REQUEST FOR PROPOSAL TO PROVIDE SUBSTANCE USE DISORDER (SUD) OUTPATIENT TREATMENT SERVICES FOR ADULTS AND/OR ADOLESCENTS

DUE: October 23, 2025

TIME: Before 11:00 a.m.

COUNTY OF KERN

KERN BEHAVIORAL HEALTH & RECOVERY SERVICES

Request for Proposal to Provide Substance Use Disorder (SUD) Outpatient Treatment Services For Adults and/or Adolescents

The County of Kern is seeking qualified Contractors to provide **Substance Use Disorder (SUD) Outpatient Treatment Services for Adults and/or Adolescents in Kern County**.

Proposers are specifically directed not to contact any County personnel, other than the Contact Person indicated below, for any purpose related to this RFP. **Unauthorized contact of any County personnel may be cause for rejection of a vendor's proposal.** All inquiries concerning this RFP should be directed to the following Contact Person:

Kern Behavioral Health & Recovery Services
2001 – 28th Street
Bakersfield, CA 93301
jscales@kernbhrs.org

Envelopes containing the Proposals are to be marked:

PROPOSAL: "**Substance Use Disorder (SUD) Outpatient Treatment Services For Adults and/or Adolescents"**

The following dates are set forth for information and planning purposes only. These dates may be changed by County upon notice to prospective proposers:

Issuance Date . . . . September 11, 2025
Pre-Proposal Meeting . . . . September 25, 2025
Proposal Due Date . . . . October 23, 2025
Proposal Due Time . . . . Before 11:00 a.m.

Postmark date will not constitute timely delivery. Responses received after the above time **will not** be considered. Proposers are solely responsible for ensuring timely receipt of their Proposals. If hand delivery is planned to our offices, please be aware that delays through building security protocol should be planned for by the proposer since timely receipt of all Proposals is required.

TABLE OF CONTENTS

	PAGE NUMBER
I. GENERAL INFORMATION	
A. Project Background and Description	4
B. Services Required of Successful Proposer	9
C. Services Provided by the County	9
D. Selection Process - Protest Process	9
E. Solicitation Caveat	13
F. Time	14
G. Standard County Agreement	14
H. Insurance Requirements	14
I. Modifications to Scope of Work	17
J. News Releases	17
K. Compensation	17
L. Statutes and Rules	17
M. Background Review	18
N. Organizational Conflict of Interest	18
II. PROPOSAL INFORMATION AND REQUIREMENTS	
A. General Instructions	18
B. Business Address	18
C. Corrections and Addenda	19
D. Proposal Format	19
D1. Proposal Contents	19
E. Disposition of Proposals and Proprietary Data	27
F. Post RFP Issuance	27
G. Proposal Submission	28
H. Withdrawal and Submission of Modified Proposal	28
SCOPE OF WORK SPECIFICATIONS AND REQUIREMENTS	
Exhibit A: Description Of Standard and Standards: Outpatient Substance Treatment Services For Adults and/or Adolescents	30
Exhibit A-1: Description Of Standard and Standards: Recovery Incentives Program Description	76
Exhibit A-2: Description Of Standard and Standards: Penal Code 1000 Drug Diversion Program	96
AGREEMENT FOR PROFESSIONAL SERVICES Exhibit B – Sample Excerpt: Professional Services Agreements	111
KERN COUNTY ADMINISTRATIVE BULLETIN Exhibit C- Free Speech Policy	127
APPENDIX I Proposal Checklist and Outline	20

I. GENERAL INFORMATION

A. Project Background

Kern County spans 8,161 square miles in the San Joaquin Valley of California. The County is divided into eleven (11) Geographic Service Areas for serving individuals who need behavioral health care. The Kern Behavioral Health and Recovery Services (KernBHRS) administration office is located in Bakersfield, the county seat, in the southern region of the San Joaquin Valley.

The Department operates under the directorship of Ms. Alison Burrowes, MA, LCSW and is governed by the five (5) members of the Kern County Board of Supervisors (BOS). The Department strives to promote its mission statement, “Working together to support hope, healing, and recovery”.

The Department’s goal is to ensure the citizens of Kern County who are afflicted with behavioral health disorders, including mental health and substance use disorders, are provided with services and resources necessary for their treatment and recovery. The Department utilizes the services of contracted providers to deliver behavioral health treatment services for adults and minors in most geographic areas throughout Kern County.

The Substance Use Disorder Division at Behavioral Health and Recovery Services (BHRS) provides support for individuals who are at risk of developing substance use disorders or who are currently struggling with a substance use disorder. Several modalities are available, including:

- **Outpatient Treatment**: Group and individual counseling sessions a few times per week.
- **Intensive Outpatient Treatment**: More frequent counseling to help establish recovery skills.
- **Residential Treatment**: Short-term, intensive treatment at a licensed live-in facility, followed by outpatient care.
- **Narcotic Treatment Programs**: Daily medication to treat opioid or alcohol use disorder, combined with counseling.
- **Contingency Management**: Treatment that provides motivational incentives to reinforce positive behavior change for an individual to reduce the use of stimulants.
- **Drug Diversion Program (PC 1000):** A self-pay program that permits first-time drug offenders with no prior criminal record to participate in a four (4) month, weekly class in lieu of incarceration.

This Request for Proposal (RFP) is seeking qualified contractors to provide services that include Outpatient Substance Use Treatment Services for Adults and/or Adolescents, and services which may include Drug Intervention Services (PC 1000) and/or Contingency Management Services in designated geographic service areas throughout Kern County. Proposers may submit proposals for one or more services in one or more regions.

The services include:

- Adult Outpatient Substance Use Treatment Services.
- Adolescent Outpatient Substance Use Treatment Services; or
- Adult and Adolescent Outpatient Substance Use Treatment Service
- Drug Diversion Program Services (PC 1000)
- Contingency Management Services

The regions include:

- Arvin
- Bakersfield
- Delano
- Lake Isabella
- Lamont
- Lebec/Frazier Park
- Ridgecrest
- Taft
- Tehachapi/Mojave
- Wasco

Contractor(s) shall provide these services in a welcoming, recovery-oriented, family inclusive, culturally competent, and co-occurring capable manner. The levels of service will be delivered in accordance with the American Society of Addiction Medicine (ASAM) criteria. Outpatient Substance Use Treatment Services for Adults and/or Adolescents shall include but not be limited to:

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

a. Description: Early intervention services are covered DMC-ODS Services for beneficiaries under the age of twenty-one (21). Any beneficiary under the age of twenty-one (21) who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. All DMC-ODS claims shall include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" as described in BHIN 22-013. Early intervention services may be delivered in a wide variety of settings and can be provided in person, by telehealth, or by telephone.

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

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

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

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

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

b. Services: Outpatient services shall include the following:

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

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

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

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

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

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

a. Description: Intensive outpatient services are provided to beneficiaries when medically necessary in a structured programming environment. These services may be offered for a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for clients under the age of 21 with a focus on recovery or motivational enhancement. Services may exceed the maximum based on individual medical necessity.

b. Services: Intensive Outpatient Services include the following:

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

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

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

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

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

4. Contingency Management (optional)

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

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

i. Participation in the **Recovery Incentives Program** is optional for DMC-ODS providers, participating providers must receive KernBHRS SUD Administrator Approval and follow the program specifications.

5. Drug Diversion Services, PC 1000 (optional)

a. Description: The PC 1000 Drug Diversion Program is an alternative sentencing option for eligible first-time drug offenders in Kern County, authorized under California Penal Code Section 1000. The program is designed to educate clients on substance use, promote behavioral change, and prevent future drug-related offenses. Upon court referral, criminal proceedings are suspended, allowing the individual to complete a certified program in lieu of

prosecution. The program is overseen by KernBHRS in collaboration with the courts and the Probation Department.

b. Services: The program provides a structured curriculum that includes an initial orientation, 18 hours of educational sessions on substance use and life skills (goal setting, communication, and coping), and 12 hours of peer support. Clients are required to attend 24 hours of self-help meetings (such as AA/NA) and undergo three random drug screenings. Additional support includes referrals to ancillary services based on individual needs, culturally and linguistically appropriate programming, financial assistance options, and an exit interview to evaluate client progress and satisfaction. Clients are required to pay for program participation.

i. Participation in the **PC 1000 Program** is optional for DMC-ODS providers, participating providers must receive KernBHRS SUD Administrator Approval and follow the program specifications.

The Department expects to spend approximately $12,000,000 per fiscal year for these services. Agreements will be negotiated between BHRS and the prospective service provider and approved by the Kern County Board Of Supervisors prior to service delivery. Services shall begin on July 1, 2026.

Additionally, the successful proposer will be required to comply with the following prior to proceeding with performing the provisions of the contract:

1. Disclosure of Ownership: provide disclosures of ownership and control. A Disclosure of Ownership form will be provided to the successful contractor by KernBHRS once a contract is awarded.

2. Screening for Ineligible and Suspended Employees and Entities (Exclusions): evidence that the contractor is not identified on the List of Excluded Individuals/Entities (LEIE), the General Services Administration Excluded Parties List System (SAM-EPLS), the DHCS Medi-Cal List of Suspended of Ineligible Providers nor the Social Security Administration’s Death Master File (SSA DMF), and that the contractor will not employ individuals or contract with individuals or vendors that are excluded from participation in Federal health care programs. Additionally, KernBHRS has a process in place to verify the accuracy of new and current (prior to contracting with and periodically) providers and contractors in the National Plan and Provider Enumeration System (NPPES).

3. Credentialing Requirements: evidence that the assigned staff to perform the services under the provisions of the signed contract as a result of this RFP are:

Qualified in accordance with current legal, professional, and technical standards and are appropriately licensed, registered, waivered and/or certified.

Must be in good standing with the Medicaid/Medi-Cal programs.

Any staff excluded from participating in Federal health care programs, including Medicare or Medicaid/Medi-Cal, may not participate in performing the provisions of the signed contract as a result of this RFP.

4. Pre-Award Risk Assessment: this form is an evaluation of the proposer's history, performance, financial status, and the management systems of the organization. This tool allows KernBHRS to determine if adequate systems are in place to appropriately account for allowable and unallowable costs, documentation of expenditures, allocation of costs, cash management, and internal controls.

5. W-9: a completed W-9 form identifying the business entity, federal tax classification and tax identification number (either SSN or EIN).

6. Corporate Compliance: evidence of a comprehensive Corporate Compliance Program that includes auditing, monitoring, and reporting methods designed to guard against fraud, waste, and abuse.

7. Credentialing, Exclusion Reporting and Corporate Compliance Form (CECC): a form to be completed by the successful contractor regarding credentialing, exclusion reporting and corporate compliance program.

8. Insurance Certificate: evidence of insurance as required by the County of Kern that includes all necessary endorsement forms and language to perform the provisions of the contract.

B. Services Required of Successful Proposer

BHRS has developed the attached sample **Exhibit A, Description and Standards of Services** which fully describes the scope of work and services required; deliverables; benchmark requirements; and our anticipated timeline for the start and completion of this project.

Proposer will be expected to review the Exhibit to understand the expected outcome, what the desired goals and objectives are, what specific problems and challenges need to be solved in order to achieve the required end result. **Detailed description is available in the sample Exhibit A, Description and Standards of Services.**

C. Services Provided by the County

The County will provide a Contact Person as a primary contact, who will arrange for staff assistance by other County staff as may be required. County will also provide whatever information as may be available. County will also be available to meet and discuss project requirements and development at key times in the process.

D. Selection Process

1. All Proposals received by the specified deadline will be reviewed by a County Evaluation Committee. After the initial scoring, the Evaluation Committee may select those firms deemed most qualified for this project for further evaluation. Interviews of these selected firms may be conducted as part of the final selection process. Proposers are advised that the County, at its option, may award a contract strictly on the basis of the initial Proposals, and not create a short list of Proposals for further consideration. The firm selected by the Evaluation Committee will be recommended to the Board of Supervisors for this project, but the Board is not bound to accept the recommendation or award the project to the recommended firm.

2. If one or more of the proposers is a local vendor as defined herein, said proposer(s) shall be entitled to a local vendor preference as herein described, provided: (i) said proposer(s) achieved a score of at least seventy percent (70%) during the initial scoring phase by the Evaluation Committee; and (ii) they were included in the short list of proposers for further consideration by the Evaluation Committee, if the Evaluation Committee elected to create a short list of Proposals.

All local vendors meeting the above stated criteria shall have their final evaluation score increased by five percent (5%) for purposes of determining the Evaluation Committee's final selection for recommendation to the Board of Supervisors.

A local vendor is defined as a proposer who:

(a) Has had a fixed office or distribution point located in and having a street address within the county for at least six (6) months immediately prior to the issuance of the request for competitive bids by the purchasing agent

(b) Holds any required business license by the county or a city within the county; and

(c) Employs at least one (1) full-time or two (2) part-time employees whose primary residence is located within Kern County, or if the business has no employees shall be at least fifty percent (50%) owned by one or more persons whose primary residence is located within Kern County.

All local vendors with a Local Employee Ratio of 50% or higher will receive an additional 2% score increase, and those with a ratio of 100% will receive a 3% increase to their score. (Rev 11/19)

(d) Will credit all sales taxes generated pursuant to the contract awarded as a result of the application of this local vendor preference to its business location in Kern County.

This local vendor preference shall not apply to any contracts funded in whole or in part with federal or state funds which do not allow the use of local preferences, or any other contracts which are statutorily or otherwise precluded from the use of local preferences during the selection process.

<u>At-Risk Employer Preference</u>
Per County Ordinance 2.38.132, the At-Risk Employer preference will be implemented. This ordinance provides a preference to local vendors who are also at-risk employers. If there is a tie for the low bid and both bidders are local vendors but one of the bidders is also an at-risk employer, the contract shall be awarded to the low bidder that is also the at-risk employer. In the event local vendors are allowed to submit a new bid equal to or less than the out of county low bidder, and there is a tie for the low bid and one of the responsible low bidders is also an at-risk employer, the local vendor who is also an at-risk employer will be awarded the contract

To qualify as an "At-Risk Employer," Vendor shall state below that you have provided gainful employment to "at-risk" individuals residing in Kern County for at least one (1) year prior to submitting this bid; and you continue to provide gainful employment to 'at-risk individuals. "At-Risk Individuals" are defined in County Ordinance 2.38.132 as those individuals who have been incarcerated within the last five (5) years and/or have been convicted of a misdemeanor or felony within the last five (5) years and/or are youth in foster care.

Vendor has employed at least one (1) at-risk individual residing in the County of Kern for at least one year prior to submitting a bid for this project and continues to provide gainful employment to at-risk individuals residing in the County of Kern.

3. The following is a list of general criteria that will be used by the Evaluation Committee to determine its recommendation to the Board of Supervisors. (Please note that the Evaluation Committee may consider other additional information they deem relevant in determining a recommendation to the Board of Supervisors and may give each of the criteria considered as little or as much weight as they consider appropriate**.)**

(a) Proposer's understanding of the RFP requirements and end result.

i. Does proposal show comprehension of the scope of services and match Exhibit A requirements?
ii. Does proposal address all requested objectives & deliverables?
iii. Does proposal offer specific solutions that address problems & our desired objectives?

(b) Proposer's proposed approach to tasks.

i. Does the approach show innovative or advanced techniques
ii. Does the approach make sense for this project?
iii. Does the proposal clearly define deliverables? Are they measurable and realistic?
iv. Are there any apparent discrepancies or omissions in proposal?
v. Is the proposed transition or milestone implementation plans feasible?

(c) Proposer's experience in similar projects.

i. Does proposer have a proven track record with similar projects?
ii. Has proposer completed relevant or similar projects? What was the length of time performing services for these relevant projects?
iii. What is the overall exposure/experience of the proposer with government sector projects?
iv. Does proposal provide types, number & duration of current and previous contracts?

(d) Fee OR proposed rates.

i. Has proposer revealed and described all costs? Are there any hidden costs?
ii. How does the proposer implement cost control techniques? Are there any escalation clauses included?
iii. Does proposer list prior contracts that were conducted on time and within budget?
iv. Does proposal state length of time for firm pricing?

(e) Estimated completion date(s) or required start date

i. Does proposal describe transition start up tasks & time and/or milestone steps to negotiate contract, set up staffing/equipment requirements and begin services?
ii. Does proposal address any time frames mandated by law?
iii. Does proposal address the length of time to complete one-time services?
iv. Does proposal describe in detail each project phase and the time needed for completion?
v. Does the proposal benchmark critical events in the completion of the project?

(f) Client references.

i. Are proposer's referenced projects similar in size & scope?
ii. Do references report any negative aspects with their experience with proposer?
iii. Do references report proposer's capabilities in problem solving during project?
iv. Do references indicate successful billing/invoicing processes?
v. How did the reference award previous business to the proposer?

(g) Qualifications of proposer's staff for the project.

i. Does proposer offer a combination of experience, education, licensing, certification & background undertaking with similar projects relevant to our needs?
ii. Is the technical experience of proposer's personnel specific to the needs detailed in Exhibit A?
iii. Does proposer's response address productivity and utilization of staff/management assignments?

(h) Any other factors the Evaluation Committee deems relevant, for example:
i. Does proposal offer technology advances included in work approach?
ii. How feasible is the transition plan/milestone steps of proposer's plan?
iii. Other

4. The County reserves the right to reject any and all Proposals and to waive informalities and irregularities in any Proposals received. Absence of required information may render a Proposal non-responsive, in the sole discretion of the County, resulting in rejection of the Proposal.

5. The County may, during the evaluation process, request from any proposer additional information which the County deems necessary to determine the proposer's ability to perform the required services. If such information is requested, the Proposer shall be permitted five (5) working days to submit the information requested.

6. An error in the Proposal may cause the rejection of that Proposal; however, the County may, in its sole discretion, retain the Proposal and make any corrections it deems appropriate. In determining if a correction will be made, the County will consider the conformance of the Proposal to the format and content required by the RFP, and any unusual complexity of the format and content required by the RFP. If the proposer's intent is clearly established based on review of the complete Proposal submittal, the County may, at its sole option, correct an error based on that established content. The County may also correct obvious clerical errors. The County may also request clarification from a proposer on any item in a Proposal that County believes to be in error and make corrections accordingly.

7. The County reserves the right to select the Proposal which in its sole judgment best meets the needs of the County. The recommendation by the Evaluation Committee, and the final selection of a proposer by the Board of Supervisors, shall be based on any information and criteria the Evaluation Committee and Board consider relevant, which may include criteria not listed in paragraph 2 above. **The lowest proposed cost is *not* the sole criterion for recommending contract award.**

8. All proposers responding to this RFP will be notified of their selection or non-selection in writing.

a. **All proposers shall have seven (7) calendar days from the date of the written notice to submit any additional information not previously submitted to the County representative for final consideration.**

b. **Proposers may request a debrief during the same seven (7) daytime period. No extension will be given.**

9. The County representative will notify the proposers in writing of the date the Department's recommendation is placed on the Board of Supervisors' agenda.

a. Protest Process

Any bidder or contractor who is allegedly aggrieved in connection with the solicitation or award with a contract may protest. The steps for protest are as follows:

1. If a proposer is unsatisfied with the outcome of the debriefing meeting, they are provided with the Kern County Protest Procedures.
2. The bidder shall exhaust the Kern County Protest Procedures for Request for Bid/Quotation outlined in the Kern County Adminstrative Policy and Procedures Manual Chapter 5 (5:30).
3. KernBHRS will render a decision within 30 calendar days from the date the protest is filed.
4. If KernBHRS fails to render a decision within 30 calendar days from the date the protest is filed, the bidder's protest shall be deemed denied and the bidder may appeal the failure to the Department of Heath Care Services.

10. County employees will not participate in the selection process when those employees have a relationship with a person or business entity submitting a Proposal which would subject those employees to the prohibition of Section 87100 of the Government Code. Any person or business entity submitting a Proposal who has such a relationship with a County employee who may be involved in the selection process shall advise the County of the name of the County employee in the Proposal.

11. Any person or business entity which engages in practices which might result in unlawful activity relating to the selection process including, but not limited to, kickbacks or other unlawful consideration paid to County employees, will be disqualified from the selection process.

12. The process, procedures and evaluation criteria used by County in developing and issuing this RFP and evaluating the Proposals received for purposes of making a recommendation to the Board of Supervisors shall be determined in the sole discretion of the County. Potential proposers shall have no rights whatsoever regarding the processes and procedures used by the County relating to this RFP or the manner in which a proposer is selected by the Board of Supervisors, provided their decisions are not arbitrary and capricious, and there is some reasonable basis for the selection(s) made.

E. Solicitation Caveat

The issuance of this solicitation does not constitute an award commitment on the part of the County, and the County shall not pay for costs incurred in the preparation or submission of Proposals. **The County reserves the right to reject any or all Proposals or portions thereof if the County determines that it is in the best interest of the County to do so.**

Failure to furnish all information requested or to follow the format requested herein, or the submission of false information, may disqualify the proposer, in the sole discretion of the County. The County may waive **any** deviation in a Proposal. The County's waiver of a deviation shall in no way modify the RFP requirements nor excuse the successful proposer from full compliance with any resultant agreement requirements or obligations.

F. Time

Time and the time limits stated in this RFP are of the essence of this Request for Proposal.

G. Standard Agreement For Professional Services

No agreement with the County is in effect until a contract has been signed by both parties. Attached to this RFP as **Exhibit "B" is the Sample Standard Agreement For Professional Services** which are in substantially the form the successful proposer will be expected to sign. The final agreement may include the contents of the RFP, any addenda to this RFP, portions of the successful proposer's Proposal and any other modifications determined by the County to be necessary prior to its execution by the parties.

Until such time as the Evaluation Committee has completed its deliberative process and the matter has been set for consideration before the Board of Supervisors, the agreement and all documents and materials relating thereto, the negotiation and execution thereof, including, without limitation, the existence of the Agreement and the negotiations taking place between the parties, shall be confidential.

The **Exhibit "B" - Sample Standard Agreement for Professional Services** is included in this RFP is for informational purposes and should not be returned with a Proposal; however, the Proposal shall include a statement that the proposer has reviewed the **Sample Standard Agreement for Professional Services** and either:

i) will agree to and accept the **Exhibit "B" Sample Standard Agreement for Professional Services** contained therein if selected, or

ii) indicate those specific provisions of the **Sample Standard Agreement for Professional Services** to which the proposer takes exception and why. Raising significant exceptions in a Proposal, as determined in the sole discretion of the County, may be cause for rejection of the Consultant's Proposal.

The selected Consultant will be required to execute an agreement with the County for the services requested **within 30 calendar days** of the award. If agreement on the terms and conditions of the contract that are acceptable to the County including, but not limited to, compensation, cannot be achieved within that timeframe, the County reserves the right to continue negotiations or to award the bid to another Consultant and begin negotiations with that Consultant.

Consultant must identify and provide contact information in their Proposal of the individual within their organization who is authorized to negotiate the terms and conditions of any agreement between Consultant and County.

H. Insurance Requirements

Vendor, in order to protect County and its board members, officials, agents, officers, and employees against all claims and liability for death, injury, loss and damage as a result of Vendor's actions in connection with the performance of Vendor's obligations, as required in this Agreement, shall secure and maintain insurance as described below.

Vendor shall not perform any work under this Agreement until Vendor has obtained all insurance required under this section and the required certificates of insurance and all required endorsements have been filed with the County's authorized insurance representative.

Receipt of evidence of insurance that does not comply with all applicable insurance requirements shall not constitute a waiver of the insurance requirements set forth herein. The required documents must be signed by the authorized representative of the insurance company shown on the certificate. Upon request, Vendor shall supply proof that such person is an authorized representative thereof and is authorized to bind the named underwriter(s) and their company to the coverage, limits and termination provisions shown thereon.

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

a. Workers' Compensation and Employers Liability Insurance Requirement:
In the event Vendor has employees who may perform any services pursuant to this Agreement, Vendor shall submit written proof that Vendor is insured against liability for workers' compensation in accordance with the provisions of section 3700 of the California Labor Code.

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

Vendor shall also maintain employer's liability insurance with limits of **one million dollars ($1,000,000) for bodily injury or disease.**

b. Liability Insurance Requirements:

(1) Vendor shall maintain in full force and effect, at all times during the term of this Agreement, the following insurance:

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

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

(c) Professional Liability (Errors and Omissions) Insurance, for liability arising out of, or in connection with, the performance of all required services under this Agreement, with coverage equal to the policy limits, which shall not be less than **one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate.**

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

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

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

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

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

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

f. All insurance afforded by Vendor pursuant to this Agreement shall be primary to and not contributing to all insurance or self-insurance maintained by the County. An endorsement shall be provided on all policies, except professional liability/errors and omissions, which shall waive any right of recovery (waiver of subrogation) against the County. A waiver of right of recovery (waiver of subrogation) is only required on Workers' Compensation policies when a vendor's personnel deliver or perform services for the County while on County property.

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

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

I. Modifications to Scope of Work

In the event that sufficient funds do not become available to complete all the services identified in this RFP, the scope of services may be amended, as determined in the sole discretion of the County. The County may also, from time-to-time, request changes in and/or additions to the services to be provided by the successful proposer. Such changes, including any increase or decrease in compensation, which are mutually agreed upon by and between the County and the successful proposer, shall be incorporated into the contract prior to execution of the contract, and by written amendments thereto after execution.

J. News Releases

News releases pertaining to any award resulting from this RFP may not be made without prior written approval of the **Director of Kern Behavioral Health & Recovery Services**.

K. Compensation

Compensation shall be agreed upon by County and Vendor to be included in the final agreement for services.

L. Statutes and Rules

The terms and conditions of this RFP, and the resulting consulting services and activities performed by the successful proposer, shall conform to all applicable statutes, rules and regulations of the federal government, the State of California and the County of Kern.

M. Background Review

The County reserves the right to conduct a background inquiry of each proposer that may include collection of appropriate criminal history information, contractual and business associations and practices, employment histories, reputation in the business community and financial condition. By submitting a Proposal to the County, the proposer consents to such an inquiry and agrees to make available to the County such books and records the County deems necessary to conduct the review.

N. Organizational Conflict of Interest

Contractor warrants, to the best of its knowledge, that neither Contractor nor its officers, agents or employees presently has any consulting or contractual arrangement with any firm or organization that would give rise to an organizational conflict of interest with respect to the work to be performed under this Agreement. Neither Contractor nor its officers, agents or employees shall enter into any contractual arrangement that would give rise to any potential conflict of interest, without first obtaining County's prior written approval before entering the agreement. If any organizational conflict of interest is discovered by Contractor relating to this Agreement, Contractor shall immediately notify County, and attempt to present a suitable mitigation plan. County may, at its sole discretion, terminate this agreement in the event that Contractor has any actual or potential organizational conflict of interest. As used in this paragraph, **"Organization conflict of interest"** means any relationship whereby Contractor has present or planned interests related to the work to be performed under this Agreement which: (1) May diminish its capacity to give impartial, technically sound, objective assistance and advice or may otherwise result in a biased work product, or (2) may result in its being given an unfair advantage.

<u>II. PROPOSAL INFORMATION AND REQUIREMENTS</u>

A. General Instructions

To receive consideration, Proposals shall be made in accordance with the following general instructions:

1. The complete Proposal shall be without alterations or erasures. Errors may be crossed out and corrections printed in ink or typed adjacent and must be initialed in ink by an authorized representative of the proposer.

2. No oral, telephonic, telegraphic, e-mailed, or faxed Proposals will be considered.

3. The submission of a Proposal shall be an indication that the proposer has investigated and satisfied him/herself as to the selection process to be used by the County, the conditions to be encountered, the character, quality, and scope of the work to be performed, and the requirements of the County.

4. All Proposals shall remain firm for one hundred and eighty (180) days from the Proposal submission deadline.

B. Business Address

Proposers shall furnish their business street address. Any communications directed either to the address so given, or to the address listed on the sealed Proposal container and deposited

in the U.S. Postal Service by Certified Mail, shall constitute a legal service thereof upon the proposer.

C. Corrections and Addenda

If a proposer discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the proposer shall immediately notify the Contact Person of such error in writing and request clarification or modification of the document. Modifications will be made by addenda as indicated below to all parties in receipt of this RFP.

If a proposer fails to notify the Contact Person prior to the date fixed for submission of Proposals of a known error in the RFP, or an error that reasonably should have been known, the proposer shall submit a Proposal at their own risk, and if the proposer is awarded a contract they shall not be entitled to additional compensation or time by reason of the error or its subsequent correction.

Addenda issued by the County interpreting or changing any of the items in this RFP, including all modifications thereof, shall be incorporated in the Proposal. The proposer shall sign and date the Addenda Cover Sheet and submit same with the Proposal (or deliver them to **Jewelle Scales, Kern Behavioral Health & Recovery Services, 2001 28th Street, Bakersfield, CA 93301**, if the proposer has previously submitted a Proposal to the department).

Any oral communication by the County's designated Contact Person or any other County staff member concerning this RFP is not binding on the County and shall in no way modify this RFP or the obligations of the County or any proposers.

D. Proposal Format

1. The length of the proposal should be no longer than 25 - 50 pages.

2. Please use complete sentences for each section of the proposal.

3. Please Arial font and the font size should be 12.

4. Please do not include **Patient Health Information** in this or any other section of your proposal. This will be grounds for immediate disqualification from the RFP process.

5. **Please do not submit canned or generic proposals.** (A "canned" submission is one that is being repurposed from a previous proposal. Submission should be specifically written for this RFP.)

6. For ease of review and to facilitate evaluation, the Proposals for this project must be organized and presented in the order requested as follows **(no exceptions):**

D1. Proposal Contents

1. Cover Page:

Clearly indicate the RFP project title and the name of the firm on the cover page. For example:

Request For Proposals For:
Substance Use Disorder Outpatient Services for Adults and/or Adolescents
Submitted By: Organization X
James Smith, Chief Operating Officer

Please clearly indicate if the proposed services are for Adults only, Adolescents only, or both Adults and Adolescents.

2. Introduction (1 Page):

Include a letter of introduction about your organization signed by an authorized representative of the firm.

State whether the proposal being submitted is to provide:

- Adult Outpatient Substance Use Treatment Services;
- Adolescent Outpatient Substance Use Treatment Services; or
- Adult and Adolescent Outpatient Substance Use Treatment Services.

In your introductory statement please include the following language at the end of your introductory statement:

❖ The undersigned certifies that all statements in the Proposal are true and correct; and that any material false statement contained in this proposal shall entitle Kern County to pursue any and all remedies authorized by law and/or declare any contract made as a result thereof, to be void.

Please include an **email address** that we may use to contact your organization.

3. Checklist Table

Use the Checklist Table below to indicate which region(s) services will be provided in and specify whether the services are for Adults, Adolescents, or both.

Region	Adult	Adolescent	PC 1000	Contingency Management
Arvin				
Bakersfield				
Delano				
Frazier Park				
Lake Isabella				
Lamont				
Ridgecrest				
Taft				
Tehachapi / Mojave				
Wasco				

4. Corporate/Agency Profile:

Provide specific information concerning the firm in this section, including all of the following:

- The legal name, address and telephone number of your company

- The type of entity (sole proprietorship, partnership, or corporation and whether public or private).
- Whether you are a local Kern County vendor as defined in section I.D.2. of this RFP (provide the street address of the local office).
- The name and telephone number of the person(s) in your company authorized to execute the proposed contract.

5. Organization's Qualifications and Experience:

This section is designed to establish the proposer as an organization with the qualifications and experience to operate the program, or provide the services, as specified in the RFP's scope of work, **Exhibit A, Description and Standards of Services**.

In this section, the proposer must provide specific information concerning the organization's qualifications and experience (e.g., skill sets, contractor licensing, certifications etc.) in the services specified in the RFP's scope of work, **Exhibit A, Description and Standards of Services**, preferably within the State of California.

Part I: Headers

Please provide information for each Header in this section (in this order):

- Header #1: The number of staff (key and non-key) involved in providing services
- Header #2: Number of years the organization has been providing services
- Header #3: Skill sets that organization uses in providing services
- Header #4: Contractor licensing, if applicable
- Header #5: Certifications, if applicable
- Header #6: Examples of completed projects

Part II: Financial Statements

Please provide information for this Header:

- Header #7: Financial statements (balance sheet and Dun & Bradstreet credit rating acceptable)
- The Dun & Bradstreet credit report will not be counted toward the maximum number of pages.

How to obtain Dun & Bradstreet (D&B) credit scores

- ❖ The first step on how to get a D&B rating is to create a D-U-N-S number — which you can request online. In some cases, you might find that your number has already been created for you based on searches by your suppliers, clients or lenders.
- ❖ Once the D-U-N-S number is created, you can establish your business credit file and sign up for CreditSignal, which alerts you when there are changes to your score.
- ❖ Full reports are behind a paywall, which requires you to sign up for one of the packages.

Part III: Documentation of Satisfactory Past Performance/References

Documentation of Satisfactory Past Performance/References

Provide a minimum of three (3) reference letters for similar services rendered (must be within the last twelve (12) months on the reference **company's letterhead.**

Each reference shall include a current point of contact and a phone number.

Each reference letter must have all the following information:

- Date of the original contract;
- End date of the contract;
- Services rendered;
- Names, addresses, email and telephone numbers of contact persons within organizations /agencies for whom the services have been provided.

Notes:

- ❖ Organizations will lose points if the references are not on the company's letterhead, providing the reference.
- ❖ Organizations will lose points **if letters of support** instead of letters of reference are submitted.

Part IV: Similar Services Over The Last Two Years

Provide a list of all organizations with current contact information including email, to which you have provided similar services over the last two years but are not currently working for. Please indicate why you are not currently providing services to said organization(s).

Format Example:

- Name Of The Organization:
- Name Of The Contact:
- Contact's Email Address:
- Contact's Phone Number:

- Why is your organization no longer providing services to this organization (Keep responses to 2 to 3 sentences):

6. Credentials/Resumes:

Of critical importance is the composition of the team proposed to provide services on this project. Credentials and resumes of the person(s) responsible for administering or providing the services must be provided.

In this section, include the following information:

Part I: Organizational Chart

An organizational chart displaying all the key personnel assigned to the project and/or delivery of services. **(1 page)**

Part II: Resumes

Resumes of all key personnel assigned to the project and/or delivery of services as designated in the organizational chart.

Part III: Training Certifications

Training certifications of all key personnel assigned to the project and/or delivery of services as designated in the organizational chart.

Part IV: Summary Of The Statement Of Qualifications

A summary of the statement of qualifications for each key personnel assigned to the project and/or delivery of services, in the organizational chart, to include the following**:**

- ❖ General Experience as it relates to the project and/or delivery of services
- ❖ Education as it relates to the project and/or delivery of services
- ❖ Training as it relates to the project and/or delivery of services
- ❖ Credentials as it relates to the project and/or delivery of services

Part V: Subcontractors and/or Consultant Firms

List subcontractors and/or consultant firms, if any, that you plan to use for this project and their relevant experience.

Format Example:

- ❖ Name Of The Subcontractors and/or Consultant firms:
- ❖ Contact Name:
- ❖ Email Address:
- ❖ Phone Number:
- ❖ What is their relevant experience as it relates to the RFP’s scope of work outlined in Exhibit A – Description and Standards of Service (Keep responses to 2 to 3 sentences):

7. Project Approach, Work Schedule, Transition Plan and Technology Requirements:

Note: As your organization drafts this section of the proposal, please answer each statement and ensure that your responses are no longer than 250 words.

Part I: Project Approach

a. Provide a detailed description of the project approach proposed by your organization to perform all required services as specified in the RFP's scope of work, Exhibit A – Description and Standards Of Services **(250 words).**

b. Provide a detailed description of the methodology proposed by your organization to perform all required services as specified in the RFP's scope of work, Exhibit A – Description and Standards Of Services **(250 words).**

c. Identify the deliverables that will be produced as specified in the RFP's scope of work, Exhibit A – Description and Standards Of Services **(250 words).**

d. Describe the actions that will be performed by your organization in order to comply and meet required benchmarks, performance standards and quality assurance measures **(250 words).**

e. Describe your organization's approach and/or methodology that will be used to address obstructions, constraints, or roadblocks that may occur in providing services **(250 words).**

f. Describe how your organization's Business and Work Environment will assist with the delivery of services as specified in the RFP's scope of work Exhibit A – Description and Standards Of Services **(250 words).**

Part II: Work Schedule

g. Include specific details with regard to a work schedule which contains an aggressive plan describing how your organization will implement the services as specified in the RFP's scope of work Exhibit A – Description and Standards Of Services **(250 words).**

Part III: Transition Plan

h. Include specific details with regard to a transition plan (e.g. from an existing provider to new provider) which contains an aggressive schedule that describes how your organization will start up the services as specified in the RFP's scope of work before **July 1, 2026**. **(250 words).**

Part IV: Technology Requirements

i. Detail and describe security clearance and information technology requirements that your organization has in place to ensure HIPAA compliance **(250 words).**

j. Specify all software and computer technology **(if applicable)** that is anticipated to be used in rendering the services as specified in the RFP's scope of work Exhibit A – Description and Standards Of Services. If the Proposal includes the purchase of any software by the BHRS, provide a copy of any software license agreements that BHRS would be required to execute **(250 words).**

Note: Do not include brochures and advertisements in your Proposal

8. Cost of Service:

The Proposal shall clearly state all of the costs associated with the project, broken down by category of products and services, and all on-going costs for recommended/required products/services such as maintenance.

Note: Please use a budget template that reflects the abovementioned information. The department does not have a specific template.

The budget presented in this RFP is an estimate only. Awarding a contract as a result of this RFP is in no way guaranteeing that the County accepts and approves the submitted budget. The actual budget for each contract will depend on available funding at the time of contract award.

As a general rule, the County prefers a set price or hourly rate for the entire term of any contract. Price escalators such as the **Consumer Price Index** may also have a detrimental impact on the proposer's score determined by the Evaluation Committee and are disfavored by Kern County.

The project costs should include all expenses that will be charged to the County including but not limited to costs for shipping, insurance, communications, documentation reproduction, travel, taxes, etc. **Failure to not clearly identify all costs associated with the Proposal may be cause for rejection of the Consultant's Proposal.**

9. Insurance:

The selected proposer will be required to obtain, as a condition of the award of a contract, and **the Proposal shall state that the proposer will obtain the insurance as required in the attached agreement.**

All insurance shall be issued consistent with the final Agreement with County. Insurance coverage at a minimum must be provided by a company or companies listed in the current "Best's Key Rating Guide" publication with a minimum of A-, VII rating, or in special circumstances, as pre-approved by the Risk Management Division of the Office of County Counsel. The selected proposer shall file with the Contact Person a Certificate(s) of Insurance stating the required coverages are in effect.

10. Additional Information:

a. Include any additional information and options that you feel may be advantageous to the County. Label options clearly and specify all costs and fees associated with each option.

b. Include any other information you believe to be pertinent but not required.

c. Attachments & Appendixes must be a part of the proposal and not sent as separate documents.

11. Confidential Information:

Proposers are cautioned that because the County is a public entity, materials designated as "confidential" may nevertheless be subject to disclosure. Proposers are advised that the County

does not wish to receive confidential or proprietary information and that proposers are not to supply such information except when it is absolutely necessary.

IF CONFIDENTIAL INFORMATION IS SUBMITTED:

a. ALL CONFIDENTIAL INFORMATION MUST BE STAMPED WITH A “CONFIDENTIAL” WATERMARK AND PLACED IN A SEPARATE TABBED SECTION #9 OF THE RFP MARKED “CONFIDENTIAL”.

b. Any documents labeled “CONFIDENTIAL” shall include the following statement signed and placed on the first page of the CONFIDENTIAL material:

“______________________ (legal name of proposer) shall indemnify, defend and hold harmless the County of Kern, its officers, agents and employees from and against any request, action or proceeding of any nature and any damages or liability of any nature, specifically including attorneys' fees awarded under the California Public Records Act (Government Code §6250 et seq.) arising out of, concerning or in any way involving any materials or information in this Proposal that (legal name of proposer) has labeled as confidential, proprietary or otherwise not subject to disclosure as a public record.”

By:_________________________ Date:____________

Confidential information as discussed in this section II.D.9 may include:

Technical Information

a. Any trade secret, know-how, invention, software program, application, documentation, schematic, procedure, contract, information, knowledge, data, process, technique, design, drawing, program, formula or test data, work in progress, engineering, manufacturing, marketing, financial, sales, supplier, customer, employee, investor, or business information;

b. Any non-public business information, including, without limitation, personnel data; correspondence with governmental agencies; historical customer information and data; historical cost information such as budgets and operating expenses and capital costs; and projected capital additions and operating cost information;

Financial Information

a. Financial statements, business plans, strategic plans, proprietary market information, analyses, compilations and any other strategic, competitively sensitive or proprietary information shared between the parties as a result of the discussions contemplated by this Agreement;

Business Development-Related Information

a. All trade secrets or proprietary information protected as intellectual property that relates to the business of the Vendor and is not generally available to the public, or generally known in the industry;

b. Customers' identities and requirements, customer lists, suppliers' identities and products, pricing information, product price discount information, manufacturing processes and procedures, new product research, financial information not generally available to the public; and

c. Any techniques, know how, processes or combinations thereof, or compilations of information, records, and specifications, utilized or owned by the vendor regarding business development, marketing, pricing, business methods, strategies, financial or other analyses, policies or business opportunities.

E. Disposition of Proposals and Proprietary Data

All materials submitted in response to this RFP become the property of the County. Any and all Proposals received by the County shall be subject to public disclosure and inspection, except to the extent the proposer designates trade secrets or other proprietary data to be confidential, after the Evaluation Committee has completed its deliberative process and either the proposer has been informed that they are not the vendor selected by the Evaluation Committee for recommendation to the Board of Supervisors, or the matter has been set for consideration before the Board of Supervisors, whichever comes first.

Material designated as proprietary or confidential shall accompany the Proposal and each page shall be clearly marked and readily separable from the Proposal in order to facilitate public inspection of the non-confidential portion of the Proposal. Prices, makes, and models or catalog numbers of the items offered, deliverables, and terms of payment shall be publicly available regardless of any designation to the contrary. The County will endeavor to restrict distribution of material designated as confidential or proprietary to only those individuals involved in the review and analysis of the Proposals.

F. Post RFP Issuance

1. Questions

a. Before pre-proposal meeting: Questions may be submitted by email to: **Jewelle Scales @ jscales@kernbhrs.org. No phone calls please, only written responses will be accepted.**

b. After pre-proposal meeting: **An addendum will be issued with written responses to those questions where the answers may change the scope of services detailed in Exhibit "A.** Questions with content about the RFP process, where to mail response or other information not related to Exhibit "A" may be answered by the Project Facilitator as they are received.

c. Subsequent to addenda: Questions received subsequent to the issuance of addenda and within the last week prior to the due date and time **may** be answered. **The County will accommodate these last-minute questions but will not guarantee that they will be answered if not submitted timely.**

2. Pre-Proposal Meeting

A Pre-Proposal meeting has been set for **September 25, 2025 at 10:00 a.m.** The meeting will be held via **Microsoft Teams Meeting**. All interested parties who may have questions or wish to participate in the pre-proposal meeting must email their contact information to **jscales@kernbhrs.org. The contact information must include:**

- Organization name
- Name of the individual attending

- Phone number of the individual attending
- Email address of the individual attending

3. Purpose Of Pre-Proposal Meeting

The purpose of the conference is to permit proposers an opportunity to ask questions and/or provide feedback to County staff on specifics of this RFP.

Preliminary answers may be given at the Pre-Proposal meeting. However, these responses are only preliminary and **will not be final until they are provided as an addendum to the RFP.**

While some input obtained at the meeting may be incorporated into the RFP via addenda, **remarks and explanations made at the meeting shall not change the provisions of the final RFP**. All interested parties who may have questions are urged to attend.

G. Proposal Submission

The proposer shall **submit one (1) written copy of the Proposal and one (1) copy on thumb drive.** The thumb drive (virus free) must be a standard Microsoft Windows (Word, Adobe, Excel etc.) compatible format readable by the County; using word processing software that is Windows based, preferably Microsoft Word. Proposer agrees to be fully responsible for any damage caused by any materials submitted to County. Please submit all Proposals to:

Kern County General Services Division
REQUEST FOR PROPOSAL FOR:
OUTPATIENT SUBSTANCE USE TREATMENT
SERVICES FOR ADULTS AND/OR ADOLESCENTS
1115 Truxtun Ave., 3rd Floor
Bakersfield, CA 93301
Telephone (661) 868-3000

Proposals may be delivered in person, by courier service or by mail to the address indicated above. **ALL PROPOSALS MUST BE SEALED AND RECEIVED BEFORE 11:00 A.M. ON October 23, 2025** at the above office and address. Proposals submitted after the above deadline will not be accepted. It is strongly suggested that any proposers intending to hand deliver a proposal on the last day for submission arrive at the General Services Division third floor main lobby at least ten (10) minutes prior to the proposal receipt deadline to receive a “test” time stamp to validate the official current time. The time stamp clock in the main lobby of General Services will be the official time. Any Proposal received at or after 11:00 a.m. will be returned unopened.

Only one (1) Proposal may be submitted from each proposer. For purposes of this RFP, a proposer is defined to include a parent corporation of the proposer and any other subsidiary of that parent corporation. If a proposer submits more than one (1) Proposal, all Proposals from that proposer shall be rejected.

RFP Proposals are not publicly opened.

H. Withdrawal and Submission of Modified Proposal

A proposer may withdraw a Proposal at any time prior to the submission deadline by submitting a written notification of withdrawal signed by the proposer or his/her authorized agent. The

proposer must, in person, retrieve the entire sealed submission package. Another Proposal may be submitted prior to the deadline. A Proposal may not be changed after the designated deadline for submission of Proposals.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK.]

EXHIBIT A – DESCRIPTION OF STANDARDS AND SERVICES

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES FOR ADULTS AND/ORADOLESCENTS

I. LEVELS OF SERVICE

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

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

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

A. Level 1.0 Outpatient services for adults
B. Level 2.1 Intensive Outpatient services for adults
C. Penal Code 1000 Drug Diversion Services
D. Contingency Management Services for adults with moderate to severe Stimulant Use Disorder

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

II. GUIDING PRINCIPLES

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

The following standards are intended to be consistent with the aforementioned mission, and to provide a structure for services offered within the KernBHRS Substance Use Disorder System of Care (SUD SOC) that are not regulated under existing requirements. Providers receiving funding from Drug Medi-Cal (DMC), the Substance Use Prevention and Treatment Block Grant (SUPT) Discretionary, Perinatal Drug Medi-Cal, SUPT Perinatal Set Aside, SUPT Prevention Set Aside, and/or the Assembly Bill 109 Public Safety Realignment Act (AB 109), must also comply with the regulations and standards of those funding sources and programs. The above-mentioned funding sources and programs support an integrated approach to addressing co-occurring mental health conditions during substance use disorder treatment.

A. Contractor accepts that it is a member of a network of providers of KernBHRS's SUD SOC, a continuum of care based on American Society of Addiction Medicine (ASAM) criteria which includes prevention, early intervention, outpatient treatment, residential treatment, care coordination, recovery services, opioid treatment services and withdrawal management. Contractor readily accepts and shares the responsibility of providing quality services to all clients.

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

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

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

E. Contractor's programs and activities shall operate in a drug and alcohol-free environment. Any information produced through these funds, and which pertain to drugs and alcohol-related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. No aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol per HSC Section 11999-11999.3.

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

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

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

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

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

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

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

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

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

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

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

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

R. Contractor shall adhere to Behavioral Health Information Notice (BHIN) No: 22-022, Advertising Requirements for Substance Use Disorder (SUD) Recovery or Treatment, and Behavioral health Facilities: Passage of Senate Bill 434 and 541 (SB 434 and SB 541) as required by the Department of Health Care Services.

S. Contractor shall adhere to Behavioral Health Information Notice (BHIN) No: 23-007 Additional Advertising Requirements for Substance Use Disorder (SUD) Recovery or Treatment Facilities and Behavioral health Facilities: Passage of Senate Bill 1165 (SB 1165) as required by the Department of Health Care Services.

T. Contractor shall adhere to Behavioral Health Information Notice (BHIN) No: 23-018, Updated Telehealth Guidance for Specialty Behavioral health Services and Substance Use Disorder Treatment Services in Medi-Cal as required by the Department of Health Care Services.

III. FUNDING SOURCES AND POPULATIONS TO BE SERVED

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

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

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

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

E. Adolescent Clients: Clients under the age of twenty (21) at risk of developing a substance use disorder, and who quality for treatment under the ASAM adolescent treatment criteria.

IV. ACCESS TO TREATMENT

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

B. Contractor requirements to receive referrals:

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

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

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

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

3. Contractor shall follow the process outlined in the Protocol for Initial Service Requests and Capturing Timeliness available on KernBHRS' SharePoint.

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

E. Informing Materials:

1. Contractor shall provide clients with the KernBHRS template of the Beneficiary Handbook and the DMC-ODS Provider Directory at intake and upon request.

2. Contractor shall make the Beneficiary Handbook and the DMC-ODS Provider Directory available in English and Spanish.

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

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

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

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

F. Service Priority:

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

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

b. Injecting drug users; and

c. All others.

G. Timeliness of Access into Treatment:

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

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

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

H. Contractor may begin providing outpatient services to clients prior to their assessment or first-time service appointment as allowable by DHCS Behavioral Health Information Notices 23-068; and BHIN 24-001 and shall document these services accordingly. When access to treatment exceeds the timeliness standards described in KernBHRS Policy #5.1.12, specifically related to lack of treatment capacity, Contractor shall add appointment availability or refer clients back to the SUD Access Line if they cannot accommodate timely appointments.

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

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

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

V. SERVICES

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

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

a. Description: Early intervention services are covered DMC-ODS Services for beneficiaries under the age of twenty-one (21). Any beneficiary under the age of twenty-one (21) who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention

services. An SUD diagnosis is not required for early intervention services. All DMC-ODS claims shall include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM code list. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services” as described in BHIN 22-013. Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.

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

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

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

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

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

b. Services: Outpatient services shall include the following:

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

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

a) Contractor shall have in place a MAT policy that is in compliance with HSC Section 11834.28(c)(1)) and 11834.28(c) outlined in Behavioral Health Information Notice No: 23-054 Medications for Addiction Treatment (MAT) Services

Requirements for Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities.

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

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

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

a. Description: Intensive outpatient services are provided to beneficiaries when medically necessary in a structured programming environment. These services may be offered for a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for clients under the age of 21 with a focus on recovery or motivational enhancement. Services may exceed the maximum based on individual medical necessity.

b. Services: Intensive Outpatient Services include the following:

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

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

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

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

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

4. Contingency Management

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

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

i. Participation in the **Recovery Incentives Program** is optional for DMC-ODS providers, participating providers must receive KernBHRS SUD Administrator Approval and follow the program specifications.

B. Coordination and Continuity of Care

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

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

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

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

ii. Be developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1). Relias course "Person-Centered Planning in Behavioral Health" (REL-BHC-0-PCPBH) is recommended for direct service provider staff.

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

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

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

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

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

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

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

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

h. Contractor shall ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

2. Treatment Modifications:

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

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

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

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

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

b. Services shall continue at the assigned program and level of care until the treatment modification form is approved, and an appointment can be secured at the requested level of care. The SUD Access Line will communicate with the requesting provider so that the client can be informed of the new provider location and appointment date and time.

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

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

C. Zero Suicide

Contractor is required to participate in KernBHRS' system-wide suicide prevention initiative. This participation includes but is not limited to mandatory screening of clients at all contacts (unless less frequent screenings are indicated) assessing, and treating individuals identified

as at risk according to the Zero Suicide Protocol as outlined in Policy 5.1.32, Zero Suicide Protocol for Suicide Safe Care.

D. Transportation

1. KernBHRS is working toward preparing for implementation of Senate Bill 43 (SB43), which made substantive changes to the Lanterman-Petris-Short (LPS) Act and amended the definitions of “gravely disabled” contained in subdivisions (h)(1)(A) and (h)(2) of Welfare and Institutions Code, Section 5008.

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

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

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

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

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

VI. CLINICAL COMPONENTS

A. Assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Level of Care Placement

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

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

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

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

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

C. Medical Necessity of Services

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

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

D. Problem List

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

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

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

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

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

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

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

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

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

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

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

E. Physical Exams

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

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

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

F. Progress Notes

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

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

2. Progress notes shall include:

a. The type of service rendered.

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

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

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

e. Location/Place of the service.

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

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

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

4. For Group Services:

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

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

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

G. Discharge Planning

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

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

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

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

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

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

b. The reason for discharge.

c. A narrative summary of the treatment episode.

d. The clients' prognosis and plan for continued recovery.

e. Current alcohol and/or drug use.

f. Vocational/educational achievements.

g. Legal Status.

h. Living situation and/or support system.

i. Transfer and referral information; and

j. Client's comments.

H. Individual Counseling

1. Individual counseling is a contact between the client alone or with a significant other, and a clinician. Each counseling session shall focus on one (1) (or more, if applicable) of the following topics:

a. Completion of the assessment process.

b. Evaluation of progress related to the client's problem list and identification of new issues pertinent to recovery from substance use.

c. Crisis intervention related to imminent relapse risk.

d. Development of a plan for discharge from treatment.

e. Focus on the treatment needs of the client by supporting the achievement of the client's treatment goals.

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

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

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

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

I. Group Counseling

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

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

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

J. Patient Education

This service consists of providing research-based education on addiction, treatment, recovery, and associated health risks. Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf. A list of participants is required to be documented and maintained by the provided to document client attendance and conform to all applicable DMC-ODS, Title 22 requirements, and BH Informational Notices regarding documentation and group size limits. Services may include topics including parenting, domestic violence, anger management, pre-natal and post-natal drug effects, and research-based health information. Human immunodeficiency virus (HIV) education and intervention topics should include the following:

1. Health Education

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

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

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

2. HIV Early Intervention Services

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

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

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

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

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

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

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

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

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

VII. COMMUNICATION WITH REFERRING AGENCIES

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

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

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

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

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

VIII. OTHER TREATMENT RELATED SERVICES

A. Drug Testing

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

a. Clinical drug testing is administered as a therapeutic tool in treatment to address denial of substance use disorder and address substance use behavior with clients. Programs may refer to the consensus document by the American Society of Addiction Medicine, Appropriate Use of Drug Testing in Clinical Addiction Medicine for additional guidance.

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

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

d. All positive test results must be discussed with the client, and such discussion shall be documented in the client record.

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

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

a. Handling of client relapses

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

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

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

B. Clinician Consultation Services:

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

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

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

C. Care coordination

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

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

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

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

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

5. Care coordination services include:

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

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

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

D. Recovery Services

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

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

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

4. Recovery Services include:

a. ASAM Assessment

b. Group and Individual counseling

c. Care Coordination

d. Family Therapy

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

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

E. Quality Management Plan: Contractor shall adhere to the KernBHRS Quality Management Plan and the performance improvement projects (PIPs) as designated by KernBHRS. Contractor shall be monitored for accessibility of services through the following applicable measures:

1. Timeliness of first initial contact to face-to-face appointment

2. Frequency of follow-up appointments in accordance with individualized problem list.

3. Access to after-hours care.

4. Strategies to reduce avoidable hospitalizations.

5. Coordination of physical and behavioral health services with DMC-ODS services at the provider level.

6. Assessment of the beneficiaries' experiences, including complaints, grievances and appeals.

7. Telephone access line and services in the prevalent non-English languages.

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

G. Self-Help Meetings

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

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

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

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

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

H. Sites of Service

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

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

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

I. Hours of Service

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

2. Hours of operation and emergency telephone numbers shall be posted in English and Spanish, and other languages that may be appropriate for the communities served, at the

main entrance, and other entrances that clients may commonly access. This posting shall include at least the agency's own crisis and after-hours phone number on the door. Similar information shall be available on a telephone answering device for after-hours and weekend coverage.

J. Medi-Cal Peer Support Services

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

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

3. Medi-Cal Peer Specialists must be certified in accordance with DHCS requirements outlined in Behavioral Health Information Notices 24-001; 23-012; 23-010; 23-003; 22-067; 22-062; 22-061; 22-026; 22-018; 22-006; and 21-041, and any additional DHCS Behavioral Health Information Notices that make changes to these requirements.

IX. SUCCESSFUL DISCHARGE FROM PROGRAM

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

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

X. DOCUMENTATION AND THE ELECTRONIC HEALTH RECORD

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

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

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

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

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

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

1. All staff shall have a complete Staff Master Worksheet (SMW) submitted to KernBHRS SUD Division, or designee, to participate in (staff credentials entered in the EHR without access to the EHR for billing purposes), and/or receive access to, the Department EHR. This document contains staff category, name, credential, start date, and a request for access to organizations' reporting programs. Maintain all staff SMWs updated with KernBHRS SUD Division, or designee for Department EHR providers to continue participation and/or access.

2. Each clinical staff member (counselor, LPHA and license-eligible LPHA, MD, etc.) shall have a National Provider Identification ("NPI") number to be eligible to bill for the services provided.

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

4. Contractor shall ensure that all staff with access to the Department EHR complete Department EHR SUD training as provided by KernBHRS and as required by the staff role and access to the Department EHR. Additional training may be required by KernBHRS if staff is associated with multiple documentation deficiencies during KernBHRS audits, reviews, or other utilization review activities.

D. Additional requirements specific to clerical staff:

1. Clerical staff is responsible for the following:

a. Editing the client demographic information for accuracy.

b. Ensuring the accuracy of client financial information.

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

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

E. Additional requirements specific to treatment staff:

1.Treatment staff are responsible for completing the following:

a. CA ASAM

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

c. Diagnosis Document based upon Assessment/Reassessment

d. Problem List

e. Individual progress notes

f. Group progress notes

g. Progress Reports (if applicable)

h. Client Health Questionnaire

i. Admission Agreement

j. Program Rules

k. Consent for Treatment Form

l. Coordinated Care Consent Form

m. Consent for Text Communication Form

n. Consent for Telehealth Form

o. Releases of Information (for KernBHRS SUD Division, client's Medi-Cal managed care plan, and others as appropriate to coordinate care).

p. My Recovery Plan (Discharge Planning)

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

F. Additional requirements specific to clinical supervisors:

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

a. Caseload Reports – to manage caseloads efficiently.

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

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

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

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

f. Additional reports as they become available.

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

H. Timeliness of Documentation

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

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

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

XI. REQUIRED POLICIES AND PROCEDURES

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

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

B. Admission and Readmission Criteria

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

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

C. Client Fees

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

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

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

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

5. Such fees shall be deducted from the treatment program's cost of providing services in accordance with Health and Safety Code Section 11987.9.

6. No one is to be denied access to treatment services because of an inability to pay.

D. Confidentiality/Information Sharing

1. Contractor shall maintain client confidentiality in accordance with Health Insurance Portability and Accountability Act (HIPAA and HITECH) and Part 2 of Title 42 of the Code of Federal Regulations.

2. Contractor shall communicate with KernBHRS staff when a valid release of information has been obtained from the client by either party.

3. Clients entering treatment as a condition of probation or parole are also required to give consent.

4. Contractor shall submit progress reports to probation, child protective services, the courts, or any other applicable referring agency at least once per month, or more often if requested by the referring agency with appropriate client consent or authorization to release information.

5. County will approve formats of progress reports.

6. Contractor shall assure all staff complete Confidentiality training including HIPPA and 42 CFR Part 2 upon hire and annually thereafter as required in Exhibit **G**, "Privacy and Information Security Provisions".

E. Cultural Competence

1. Contractor shall comply with all cultural competence requirements as stated in Paragraph 26, Cultural Competence of the agreement.

2. All services shall be delivered in a manner that respects and pays attention to the client's race, color, caste, religion, religious creed (including religious dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability, medical condition (including cancer and genetic conditions), genetic information, marital status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), gender,

gender identity, gender expression, age (40 years and over), sexual orientation, veteran or military status, domestic violence victim status, political affiliation, and any other characteristic protected by state or federal anti- discrimination law.

3. Contractor shall have the ability to provide services in the established threshold languages of the County, whether by implementation of best practices, by having bilingual staff, or as a secondary process by utilizing interpreter services. Contractor shall report bilingual staff and interpreter services agreement(s) in the Bilingual Quarterly report.

4. Contractor treatment staff shall be required to attend a minimum of six (6) hours of cultural competency training within twelve (12) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS services and annually thereafter.

5. Contractor shall strive to employ staff who represent the diversity of clients served.

6. Services must be individualized and family-oriented in the context of racial, ethnic, and cultural values. Services shall be provided to all persons who request substance use disorder treatment and meet medical necessity.

F. Grievance Procedure

1. All clients shall be informed of the procedures for grievance resolution or due process.

2. Grievance procedures for all clients shall be posted in an area easily accessible to clients.

3. The procedure shall clearly state the methods by which persons served may speak to the program supervisor for problem resolution.

4. If discussion with the program supervisor does not result in a satisfactory outcome, the client may be referred to the Patients' Rights Office, although the client is free to contact the County Alcohol and Drug Program Administrator at any time.

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

6. Discrimination Grievances: "Discrimination Grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. Contractor shall inform beneficiaries of processes for filing discrimination grievances as follows:

a. To file with KernBHRS contact:

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

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

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

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

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

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

G. Morbidity and Mortality

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

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

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

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

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

H. Treatment Perceptions Survey

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

dates and available methods of administration. Contractor shall have in place a policy or procedure outlining the process for administering the Treatment Perceptions Survey and informing clients when the survey will become available.

I. Point in Time Survey:

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

J. Program Integrity:

Contractor shall implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse as specified by 42 CFR Section 438.608. Procedures shall include the following:

1. Provision for promptly reporting to KernBHRS and DHCS all overpayments identified or recovered, specifying the overpayments due to fraud.

2. Provision to report to KernBHRS when receiving information about changes in a client's circumstances that may affect the client's eligibility including a change in the client's residence and/or the death of a client.

3. Service Verification: Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.

4. If Contractor makes or receives annual payments under this agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any subcontractor or agent, that provide detailed information about the False Claims 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.

5. Provision for the prompt referral of any potential fraud, waste, or abuse that Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

6. The Fraud, Waste, or Abuse Provision that states KernBHRS reserves the right to suspend payment to any network provider for which DHCS determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

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

a. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by completing a Complaint form, which

is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

b. Suspected Medi-Cal fraud, waste, or abuse shall be reported to DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

XII. STAFFING STANDARDS

A. Counselor Certification Requirements

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

B. Program Staffing and Supervision

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

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

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

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

b. Registered counselors will have completed at a minimum:

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

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

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

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

2. LPHAs include the following:

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

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

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

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

b. LPHAs, acting within their scope of practice, will be required to conduct intake/assessments, determination of medical necessity, create and update the Problem List, and conduct re-assessments.

3. Medi-Cal Peer Support Specialists

a. A Medi-Cal Peer Support Specialist shall be an individual in recovery with a current State approved Medi-Cal Peer Support Specialist Certification Program certification. The individual must meet all other applicable California state requirements, including ongoing education requirements.

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

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

C. Personnel Files

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

a. Application for employment and/or resume;

b. Signed employment confirmation statement/duty statement;

c. Job description;

d. Performance evaluations;

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

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

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

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

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

j. Other personnel actions.

D. Staff Competencies

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

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

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

XIII. MEETING REQUIREMENTS

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

XIV. TRAINING REQUIREMENTS

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

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

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

D. Evidence Based Practices (EBP's): Contractor shall, for all contracted modalities of treatment, incorporate Evidence Based Practices. DHCS and County approved EBP's include the following: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention,

Trauma-Informed Treatment, and Psycho-Education. Credit for courses other than the EBPs named above shall not be given unless course is approved by KernBHRS.

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

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

a. An introductory, foundational, and in-depth course for each selected EBP is required to prepare staff to put skills into practice. These one-time courses need to be within the range of two to four continuing education (2 to 4 CE) units each and completed any time prior and no later than the first twelve (12) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS services *(please note that courses meeting this requirement are not available in the Relias training system)*; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XVI. ADDITIONAL REQUIREMENTS FOR ADOLESCENT SERVICES PROVIDERS

A. Descriptions and requirements of Outpatient and Intensive Outpatient ASAM Levels of Care for Adolescents are listed in Paragraph V. Services, A. Description of Services. Contractor shall assume the following responsibilities for providing substance use disorder treatment services to adolescents:

1. Adherence to the Adolescent SUD Best Practices Guide (2020) or the latest version posted to the DHCS website.

2. Encourage the parent(s)/or legal guardian to authorize the use of the child's Medi-Cal in order to access the full array of DMC-ODS services. Parent(s)/or legal guardian will provide informed consent, authorize releases of information, and participate in treatment as clinically appropriate and respecting the wishes of the youth. Minor-consent Medi-Cal will be available in those cases where the Contractor determines involving the parent(s)/or legal guardian puts the youth at risk of harm.

3. Complete an assessment of the youth's treatment needs in accordance with County procedures, and requirements listed in Paragraph VI, Clinical Components. This should include screening for mental health disorders.

4. Provide on-site gender specific treatment groups utilizing the Matrix Model, or

other KernBHRS approved materials and evidence-based practices, including fidelity monitoring.

5. Provide approved education and intervention regarding co-occurring disorders, when appropriate.

6. Provide education regarding substance use disorder recovery issues to family or caretakers, with the appropriate authorization to release information.

7. Provide individual counseling and family therapy as needed.

8. Perform drug testing every thirty (30) days for alcohol and illicit substances. Testing shall be done at random or for cause.

9. Agree to abide by federal confidentiality regulations regarding the records of youth served in substance use disorder treatment.

10. Acquire youth's written consent for the sharing of pertinent treatment information with group home staff, referring agency, family or caretakers, and others providing services, as deemed necessary.

11. Frequency and duration of treatment will be assessed based on clinical need. Discharge from the program will be assessed on the client's progress towards treatment goals and additional requirements outlined in Section VI. Services may be provided on site, in the community, and other locations deemed clinically indicated.

12. Adolescents are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under the age of 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. Nothing in the DMC-ODS overrides any EPSDT requirements.

13. Ensure that staff have the expertise and training necessary to treat adolescents.

14. Attend and/or complete training as required by KernBHRS in order to ensure that clinical staff receive adequate instruction on the use of evidence-based practices and further expertise in delivering services to adolescents.

B. Additional requirements for school-based services:

1. Contractor shall provide treatment services at selected schools for high school aged youth enrolled at the selected schools and are referred by school staff or family members due to early indicators of substance use issues. Schools selected for on-site services will be agreed upon by Contractor and KernBHRS.

2. Services should be coordinated among KernBHRS, Contractor, and the schools to ensure that services can be rendered in an efficient manner with clarity regarding the roles and responsibilities of each entity. It is important to recognize that among youth; substance use and mental health disorders often occur within

a continuum of severity. For services to be effective, efforts should be made to match the youth's needs to the appropriate treatment intensity by offering an array of services including the involvement of family members whenever possible.

XVII. ADDITIONAL REQUIREMENTS FOR PERINATAL TREATMENT SERVICES PROVIDERS

A. Authority

1. Programs contracted to provide perinatal treatment services must adhere to and follow the most current DHCS Substance Use Disorder Perinatal Practice Guidelines.

2. If the program is providing perinatal services under an enhanced Drug Medi-Cal certification, Contractor shall adhere to the Perinatal Drug Medi-Cal regulations, contained in the California Code of Regulations (CCR), Title 22, Division 3, Health Care Services.

B. Target Population

1. To be eligible for perinatal funding, a program must serve women who are either:

   a. Pregnant and drug using; or

   b. Parenting and drug using, with a child(ren) ages birth through seventeen (17) years. Parenting also includes a woman who is attempting to regain legal custody of her child(ren).

2. For Drug Medi-Cal perinatal eligibility, women must be either pregnant or postpartum for a period up to three hundred and sixty five (365) days beginning on the last day of her pregnancy, through the end of the month in which the three hundredth and sixty fifth (365th) day occurs.

C. Admission Priority

1. The Admission Priority for women in perinatal funded services are in the following order:

   a. Pregnant injecting drug users;

   b. Pregnant substance users;

   c. Injection drug users

   d. All others

D. Basic Services

1. Programs providing perinatal drug treatment services must provide:

   a. Services specific to women, which may address, but not be limited to, issues of relationships, sexual and physical abuse, and parenting. Men may not be included in

perinatal services.

b. Educational components, which may address, but not be limited to, the following services:

   i. Educational/vocational training and life-skills resources;

   ii. TB, HIV, Hepatitis B, and Hepatitis C education and counseling;

   iii. Education and information on the effects of alcohol and drug use during pregnancy and breast feeding; and

   iv. Parenting skills building and child development information.

c. Case management services to ensure women and their children have access to:

   i. Primary medical care, including prenatal care and childcare.

   ii. Primary pediatric care, including immunizations.

   iii. Gender-specific treatment.

   iv. Therapeutic interventions for children to address developmental needs, sexual and psychological abuse, and neglect.

d. Transportation either provided or arranged for, to and from the treatment site, to obtain medical care or employment, primary pediatric, therapeutic services for children, and to and from ancillary services for women who do not have their own adequate transportation.

e. Ancillary services including, but not limited to, assistance in accessing and completing dental services, social services, community services, educational and/or vocational training and other services that are medically necessary to prevent risk to the fetus or infant.

f. Childcare must be available for program clients' children while the women are participating in on-site treatment program activities and off-site ancillary services. Activities for children may include efforts to address their developmental needs, sexual and physical abuse, and neglect issues. Childcare may be provided on-site, either through a licensed program or a licensure-exempt cooperative. The following elements define a childcare cooperative:

   i. The mothers are on-site, and the children are under their care and supervision;

   ii. The number of children is limited to no more than twelve (12) at any one time;

   iii. Child development staff present the mothers with parenting skills training, child development education, and supportive role modeling.

g. Off-site childcare facilities must be either licensed or licensure-exempt to ensure the

safety and well-being of the children.

h. Childcare must be provided for clients' children according to the following schedule:

i. For clients' children between birth and thirty-six (36) months, while the mothers are participating in the program (unless DHCS approves a waiver), on-site childcare must be provided.

ii. For clients' children who are between the ages of thirty-seven (37) months and twelve (12) years of age, on- or off-site childcare may be provided.

iii. For clients' children between ages thirteen (13) and seventeen (17) childcare may be provided if necessary and appropriate, as long as their inclusion does not negatively impact the younger children.

iv. Clients with newborn babies may attend group sessions with their newborns and care for them during group sessions.

i. Programs are required to provide for, or arrange for, primary medical care for women in treatment, including referrals for prenatal care. They must also provide or arrange for primary pediatric care, including immunizations, for dependent children.

j. Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees providing the KernBHRS-approved schedule of fee assessment and collection is applied. State General Funds cannot be used to provide medical treatment.

k. Programs must facilitate for the screening of clients' children to address the children's developmental, emotional and physical needs. Tools and referrals will address children's mental health and/or counseling needs, developmental needs, screening for sexual abuse, physical abuse and neglect, and make recommendations to the clients' for accessing these services for their children.

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

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

1. Services provided to PC 1000 clients shall not be documented in the KernBHRS Electronic Health Record (EHR), SmartCare. Services must be documented as required in

the provider's own EHR or via paper charts and secured to properly protect the client's PHI.

XIX. OTHER REPORTING REQUIREMENTS

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

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

C. Provider Directory: Contractor shall adhere to Behavioral Health Information Notice 18-020 by following the KernBHRS Provider Directory reporting process. Contractor will maintain Provider Directory entries for each program site updated and accurate at a minimum of monthly within the NACT/Provider Directory web application tool. Contractor will submit an attestation form to the SUD Administrator or designee by the third (3rd) Friday of the month for the reporting month.

D. Network Adequacy: Contractor shall adhere to Behavioral Health Information Notice 23-033 by following the KernBHRS Network Adequacy reporting process. KernBHRS will submit the data annually to DHCS using the Network Adequacy Certification Tool (NACT). Contractor will maintain accurate and valid entries for the contractor sites and staff within the NACT/Provider Directory web application tool.

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

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

G. Medication Assisted Treatment (MAT) Referral Tracking: Contractor shall track and report the number of MAT services referrals that are made to primary care providers and the KernBHRS Outpatient MAT Clinic on a monthly basis using the KernBHRS provided reporting method. Reports are due to the KernBHRS designee by no later than the 5th day of the reporting month for the previous month's data.

H. Contractor shall notify the KernBHRS SOC Administrator and QID designee of any external agency audit, review, or other utilization review immediately and no later than two (2) business days of notification. Results from external agency audits, reviews, or other utilization reviews must also be forwarded to KernBHRS SOC Administrator and QID designee within two (2) business days of review. Correction Plans for DHCS Post Service Post Payment (PSPP) reviews and Drug Medi-Cal Reviews must be submitted to KernBHRS for review and submission to DHCS.

XX. OUTCOME MEASURES

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

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

C. Other DMC-ODS Evaluation: Contractor understands that UCLA will conduct statewide evaluation of the DMC-ODS Waiver, in which Kern County will participate. Evaluation will center around areas of 1) Access, 2) Quality, 3) Cost, and 4) Coordination. Contractors will ensure that staff provide accurate information in the following areas to facilitate this process:

1. Initial appointments and timelines into services
2. CalOMS data for admission, discharge, and annual updates
3. DATARs
4. Availability to provide services in languages other than English
5. ASAM placement and assessment data
6. Information on transitions between levels of care
7. Utilization of evidence-based practices
8. Grievances
9. Survey Data

Contractor will be informed of additional survey data to be collected, including the Treatment Perceptions Survey for adults and youth. Contractor shall facilitate the process for clients completing these surveys as outlined in Paragraph XI.H.

XXI. ADDITIONAL REQUIREMENTS FOR CONTRACTORS PROVIDING DMC-ODS SERVICES AND/OR USING SUBSTANCE USE PREVENTION AND TREATMENT BLOCK GRANT (SUPT) FUNDS

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

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

C. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Contractor agrees that information produced through these funds, and which pertains to drugs and alcohol-related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol-related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC, Division 10.7, Chapter 1429, Sections 11999-11999.3). By signing this Agreement, Contractor agrees that it will enforce, and will require its subcontractors to enforce, these requirements.

D. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances: None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

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

F. **Restriction on Distribution of Sterile Needles:** No SABG funds made available through this Contract shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

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

1. Trading Partner Requirements:

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

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

   c. No Unauthorized Uses. Contractor hereby agrees that for Information, it will not use any code or data elements that either are marked "not used" in the HHS Transaction's Implementation specification or are not in the HHS Transaction

Standard's implementation specifications (45 CFR 162.915(d)).

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

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

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

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

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

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

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

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

J. Cultural and Linguistic Proficiency: To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Contract shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national

standards as outlined online at: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53https://thinkculturalhealth.hhs.gov/clas/standards

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

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

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

2. Reduce barriers to patients' accepting TB treatment.

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

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

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

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

P. Participation of County Behavioral Health Director's Association of California: The County AOD Program Administrator shall participate and represent the County in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for AOD abuse services. The County AOD Program Administrator shall attend

any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the California Behavioral Health Director's Association of California.

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

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

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

T. Federal Law Requirements:

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

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

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

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

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

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

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

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

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

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

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

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

U. State Law Requirements:

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

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

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

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

V. Additional Contract Restrictions:

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

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

W. Information Access for Individuals with Limited English Proficiency:

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

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

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

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

EXHIBIT A – 1 DESCRIPTION OF STANDARDS AND SERVICES

RECOVERY INCENTIVES PROGRAM DESCRIPTION

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

I. Service Location:

- TBD

II. Background

A. Contingency Management services are a benefit provided for Drug Medi-Cal members through the Recovery Incentives Program, a pilot Drug Medi-Cal coverage. The pilot is expected to run through December 31, 2026.

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

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

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

III. Populations To Be Served

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

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

IV. Program Standards

A. Eligibility Standards

1. CM services delivered are only covered when medically necessary and appropriate as determined by an initial substance use disorder assessment showing (1) moderate or severe StimUD as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition); (2) clinical determination that outpatient treatment is appropriate per the American Society of Addiction Medicine (ASAM) criteria; and (3) that the CM benefit is

medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving CM services.

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

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

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

5. Medi-Cal members are eligible for the Recovery Incentives Program based on having any of the related *moderate or severe* cocaine or stimulant use disorder diagnoses, including diagnoses in remission. In all instances, there must be a determination of medical necessity (which includes establishment of impairment and a covered diagnosis) to qualify for admission to the Recovery Incentives Program, and the interventions offered must be determined to be consistent with the standard of care.

6. Members under the age of 21: Covered CM services shall include all medically necessary SUD services for individuals under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in California’s Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or a SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

B. Assessment

1. The initial clinical assessment shall confirm: (1) The individual has a diagnosis of StimUD of moderate or severe from the DSM for Substance-Related and Addictive Disorders (2) outpatient treatment is appropriate per the ASAM criteria; and (3) that CM is medically necessary.

C. Documentation

1. The Contractor shall document StimUD on the problem list (or treatment plan for Narcotic Treatment Providers, NTPs) within a member's medical record. Consistent with best clinical documentation practices, Contractor shall describe all interventions utilized with the member as part of their progress notes for each service to include CM in addition to any other outpatient services, such as motivational interviewing, cognitive behavioral therapy, or community reinforcement therapy.

2. CM should not be offered to a member as a standalone treatment, but rather as one component of an individualized treatment plan. However, if a member chooses to participate only in selected services (e.g., they only participate in CM and not in other aspects of treatment), they shall not be penalized, chastised, criticized or discharged from the program for declining to participate in any treatment or recovery service or for failure to participate in all recommended treatment services. Members needing or utilizing CM must be served and cannot be denied CM or be required to participate in other aspects of a SUD treatment program as a condition of entering or remaining in a Recovery Incentives Program.

3. Contractor is responsible for providing or referring members to additional services for other non-StimUD SUDs indicated in their problem list. For example, if a member has both a StimUD and a concurrent opioid use or alcohol use disorder, the Contractor shall, in addition to providing CM, provide the member with MAT or refer the member to another provider for MAT, following the same protocol required by Contractor's Outpatient Services/NTP Services agreement's Exhibit A. Each CM visit shall be documented consistent with existing DHCS policy described in BHIN 23-068 and Contractor's Outpatient/NTP services agreement.

D. Recovery Incentives Program Opt-In Process

1. DMC-ODS counties may elect to opt in to the Recovery Incentives Program and provide CM services at any time through the duration of the CalAIM 1115 demonstration period (ending December 31, 2026). DMC-ODS counties are required to complete and submit to DHCS an Implementation Plan. The Recovery Incentives Program Implementation Plan template shall be completed and submitted to DHCS for approval. For more information on the implementation process and to access the Implementation Plan template, please visit the Recovery Incentives Program webpage."

E. Member Education/Orientation

1. Before beginning CM treatment, a Medi-Cal member must complete a thorough orientation and consent to the conditions of the program. The orientation will address the following:

i. The days/times that a member must visit the facility in order to be eligible for incentives (during weeks 1–12, two weekly visits; during weeks 13–24, one weekly visit).

ii. The manner in which incentives will be delivered as well as an understanding of how and where incentives can be redeemed, including the prohibition of using incentives to purchase alcohol, cannabis, tobacco, lottery tickets, or for any form of gambling.

iii. The availability of incentives and ongoing program participation when a member lapses or relapses and seeks readmission and the process for a member to seek readmission.

iv. Contractor's UDT procedures and an explanation and review of medications/substances that may result in false-positive UDTs.

a) An explanation that the incentives are contingent on the absence of evidence of stimulant (e.g., cocaine, amphetamine, methamphetamine) use on UDT only.

b) An explanation that opioid testing will be done for the purpose of safety, due to association with overdose deaths, but will not impact the delivery of an incentive.

c) An explanation that all positive tests will be treated the same even if they result from use of one of the medications/substances known to provide false positive UDT results.

v. The amount of the initial incentive and how the value increases with consecutive stimulant-free UDTs and how the value will be re-set to a lower value in case of a positive test or unexcused absence, and that increases will be reinstated after repeated negative UDTs. The maximum incentive a member can receive per year in the Recovery Incentives Program is $599.

vi. Signed patient agreement (containing key components required by DHCS) for each program participant, to sets forth the conditions of participation in the Recovery Incentives Program.

F. Treatment Framework

1. Incentives

i. Members will receive incentives for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. Participating members will be able to receive a maximum of $599 in total incentives per year for successful completion of the treatment protocol. Contractor shall have no discretion to determine the size or distribution of incentives. The size of the incentive will be based on the protocols in Section E.3 of this agreement.

2. Harm Reduction

i. Harm reduction is an essential component of any treatment program. According to provisional data released by the Centers for Disease Control and Prevention in May of 2022, drug overdose deaths continued to rise in the United States in 2021, surpassing 100,000 deaths. A high number of these deaths are due to the synthetic opioid fentanyl, which has been found mixed in or as a replacement for many other drugs of abuse, including benzodiazepines, opiates and other opioids, and stimulants. Given the presence of fentanyl in some stimulants, death as the result of accidental ingestion of fentanyl is a real risk for members in the Recovery Incentives Program. Contractor will:

a) Establish and implement a protocol to prescribe naloxone to all members with an opioid, sedative and/or stimulant use disorder as outlined below. Contractor shall

submit protocol to KernBHRS SOC administrator, or designee, prior to beginning services; or

b) Establish and implement a naloxone distribution protocol for members who do not obtain prescription naloxone. Contractor shall submit protocol to KernBHRS SOC administrator, or designee, prior to beginning services.

c) Provide education to each CM member regarding:

1) The risks associated with fentanyl and its presence in the illicit drug supply.

2) Harm reduction safety strategies, such as the use of fentanyl test strips and which harm reduction agencies distribute test strips for home use, based on information from the California Department of Public Health (see link).

3) Specific education regarding the use of naloxone to reverse an opioid overdose.

d) Contractor shall either replace the naloxone whenever a member needs an additional dose, due to the naloxone expiring or due to use in the community or remind a member to obtain a new dose through a pharmacy or local organization. Contractor can dispense naloxone onsite to DMC-ODS members by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, Contractor can prescribe naloxone to all DMC-ODS members who are participating in the Recovery Incentives Program and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of DMC-ODS members. The community pharmacy would bill these naloxone prescriptions to the Medi-Cal pharmacy benefit. Pharmacists may also directly dispense naloxone and bill to Medi-Cal. The staff could bring the dispensed naloxone back to the Contractor site for furnishing directly to patients. This method would enable the CM provider to better facilitate onsite access to naloxone reimbursed through the Medi-Cal pharmacy benefit.

3. Treatment Schedule

i. Overview

a) The Recovery Incentives Program will consist of two phases: (1) CM treatment and (2) CM continuing care. Phase 1 of CM treatment will consist of a 24-week outpatient program, during which incentives will be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of CM treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the stabilizing period. Phase 2 begins when a member completes the initial 24-weeks of CM treatment. The participating member will receive CM continuing care of six months or more, with treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of CM continuing care, participating members may receive treatment and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

ii. CM Treatment Weeks 1-12: Escalation/Reset/Recovery Period

a) During the initial 12 weeks of the CM treatment, participating members will visit the treatment setting in person for two treatment visits per week. Visits will be separated

by at least 48 hours, and ideally 72 hours (e.g., Monday and Thursday, or Tuesday and Friday) to minimize the chance that drug metabolites from the same drug use episode will be detected in more than one UDT. Participating members can earn incentives during each visit the UDT indicates they have a negative sample for stimulants.

b). The initial incentive value is $10 for the first sample negative for stimulants in a series. For each week the participating member demonstrates non-use of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the incentive is increased by $1.50. The maximum aggregate incentive a participating member who consistently participates and has negative UDTs can receive during this initial 12-week period is $438.

c). A “reset” will occur when the participating member submits a stimulant-positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their incentive amount will return to the initial value of $10.

d). A “recovery” of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participating member will recover their previously earned incentive level without having to restart the process, no matter when in the course of the program the stimulant use occurs. Members will not be penalized for stimulant-positive samples, even if there are several in a row, and even if the sample contains other drugs. If the member fails to achieve two consecutive stimulant- negative samples within the first 12-week period, the treatment provider and member should decide whether CM is a clinically appropriate intervention for that member, and, if necessary, modify the course of treatment and update the member’s problem list and progress notes.

iii. CM Treatment Weeks 13-24: Stabilizing Period

a). During weeks 13–24, participating members will visit the treatment setting for testing once a week. During weeks 13–18, participating members will be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative UDT, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate incentive a participating member will be able to receive during weeks 13–24 is $161. The total possible earnings during weeks 1–24 for all stimulant-negative tests is $599.

iv. Hypothetical Example: Incentive Delivery Schedule for Consistent Abstinence from Stimulants

a). Table 1 illustrates an incentive delivery schedule for a participating member in a scenario where the member has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Delivery Schedule	
Week	**Incentive for Stimulant- Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

v. Resets During Weeks 13-24 or Post-Discharge

a) Recovery from any substance use disorder is a process of change, not an endpoint. As such, despite the fact that week's 13-24 are designed to be a stabilizing period, and that a member may be ready for discharge post 24 weeks, providers need to be aware of and expect lapse or relapse from members who are further along in the process and address such occurrences without judgement.

vi. Extended Absence and Readmission Throughout CM Protocol

a) A member will be considered a readmission if they leave CM services for more than 30 days. At readmission, the member must have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.7) and confirm that the member meets the medical necessity criteria for CM. If the member has remained engaged in other services during their absence from CM, an update to the most recent ASAM assessment (or a re-assessment) is sufficient. Based on the assessment, a provider may offer other treatments as alternatives to CM if there is strong clinical evidence that CM is unlikely to produce the intended results. However, if the determination from the new assessment is that CM is an appropriate course of treatment for that member, the member may receive CM services, and the incentive structure would restart at Week 1. If the member resumes CM services, they may earn incentives starting at

the Week 1 scheduled incentive amount up to a maximum of $599 per year inclusive of all incentives earned that year, including previous Recovery Incentives Program participation. If a member leaves CM services (for any reason) and returns to the program within 30 days, they shall return to the schedule of incentives as if there was no break in service, as long as the member does not exceed the $599 annual limit inclusive of all incentives earned that year, including previous Recovery Incentives Program participation. Reaching the limit for incentives earned through the Recovery Incentives program does not mean that a member would be automatically discharged; all other clinically appropriate treatment services and/or recovery supports should continue to be offered per the member's treatment plan.

b) In rare circumstances, following completion of the CM treatment phase of the program, a member may benefit from re-entering the CM treatment phase protocol instead of proceeding to CM continuing care services. Repeating the ASAM assessment and diagnostic assessment is not required for the member to re-enter the CM treatment phase of the program. In these instances, the clinical documentation, completed (or reviewed) by an LPHA, must demonstrate that CM services are medically necessary and appropriate based on the standard of care. The documentation must clarify that outpatient treatment continues to be appropriate for the member and include the provider's reasoning for resuming CM services. In this scenario, the member still may not exceed the $599 annual limit for earned incentives, and once that limit is reached the member would no longer be eligible for the Recovery Incentives Program and 2 should be transitioned to continuing care services.

4. Contractor and Staffing Criteria

i. Eligible Contractor Eligibility and Treatment Settings

a) Contractor offering outpatient, intensive outpatient, NTPs and/or partial hospitalization services that are licensed and certified to provide Medi-Cal and DMC-ODS services are eligible to participate in the Recovery Incentives Program. Contractor shall:

1) Serve DMC-ODS members residing in Kern.

2) Require that staff providing or overseeing CM services participate in CM-specific training developed and offered by a qualified contractor designated by DHCS.

3) Undergo a readiness review by the state's contracted trainer and technical advisor to ensure that program is capable to offer CM services in accordance with DHCS standards.

4) Participate in ongoing training and technical assistance, including fidelity reviews, as requested or identified by DMC-ODS counties or DHCS through ongoing monitoring to meet DHCS standards.

5) Follow all other requirements for DMC-ODS participation as described in BHIN 24-001.

ii. CM Coordinator Requirements

a) At least one CM coordinator will administer CM services at each participating Contractor site. Practitioners eligible to deliver the CM benefit include:

1) Licensed Practitioner of the Healing Arts (LPHAs).

2) SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies.

3) Certified Peer Support Specialists.

4) Other trained staff under supervision of an LPHA (This designation only applies to CM services and does not extend to other DMC-ODS services).

b) The optimal caseload for one full-time CM Coordinator is no more than 30 members at any given time and approximately 60 to 100 members over the course of a year.

iii. CM Coordinator Responsibilities

a) The CM coordinator(s) will be the main point of contact for all members participating in the Recovery Incentives Program. The CM coordinator(s) will be responsible for adhering to CLIA protocol, collecting UDT samples, inputting test results, and supporting the delivery of incentives.

iv. CM Coordinator, Backup Coordinator, and Supervisor Training Requirements

a) The following training is required for the primary staff of the Recovery Incentives Program, the CM Coordinator, Backup Coordinator, and the Supervisor:

1) Recovery Incentives Program Overview (two-hours self-paced).

2) Recovery Incentives Program Implementation Training (two three-hour live virtual sessions).

3) Site Readiness Assessment.

4) Monthly coaching calls.

v. CM Visit Workflow

a) The CM coordinator will facilitate visits with participating members. The anticipated workflow for the first CM visit and subsequent visits is below.

vi. Intake Visit

a) During a member’s first visit, the CM coordinator will complete several steps to initiate the service, specifically:

1) Conduct eligibility check – Contractor's CM coordinator or other designated personnel will confirm the member's current Medi-Cal eligibility as well as their eligibility for the program before initiating the CM service. The eligibility check should be done via the Automated Eligibility Verification System (AEVS) for Medi-Cal.

2) Program participation consent – The CM coordinator will ask the member to complete a consent authorizing services and the secure sharing of data with DHCS and the program evaluation team, including all DHCS-required consent elements.

3) Explain the CM process and reinforce the expectations set forth in Section IV.D above.

4) Enroll the member into the Incentive Manager program – The CM coordinator will complete a member profile to enroll them into the computerized system that will keep track of incentive gift cards, hereinafter referred to as the Incentive Manager.

vii. CM Visits

a) Engage the member and initiate the visit – The CM coordinator will greet the member, review their progress in the program (e.g., weeks completed out of 24), log into the Incentive Manager and locate the member's record/profile.

b) Conduct eligibility check – The CM coordinator or other staff within the Contractor will check member Medi-Cal eligibility monthly or per Contractor policy.

c) Administer UDT – The CM coordinator will administer the UDT, including processing the results of the UDT in real time.

d) Log results in Incentive Manager – The CM coordinator will log the results of the UDT for stimulants (i.e., positive or negative).

e) Discuss results – The CM coordinator will discuss the UDT results with the member and offer other services if/as appropriate, which could include brief encouragement, motivational interviewing, and education based on the CM Coordinator's scope and training. The CM coordinator will encourage the member to meet with their counselor or LPHA. If opioid results are positive, the CM Coordinator shall document these results in the clinical chart, reinforce the risk of overdose, ensure the member has naloxone, and offer other treatment services as appropriate, including MAT if the member has a co- occurring alcohol or opioid use disorder.

f) Disburse incentives consistent with "Incentive Delivery" section below:

1) If the UDT result entered is negative for stimulants, the Incentive Manager will disburse the incentive generated by the Incentive Manager consistent with the "Incentive Delivery" section below.

2) If the UDT result entered is positive for stimulants, the Incentive Manager will not disburse an incentive.

g) Plan for next appointment – The CM coordinator will remind the member of their next scheduled appointment (date and time). The CM coordinator should offer to answer any questions before adjourning the visit.

h) Documentation – The CM coordinator shall document the visit in the chart.

i) Billing – The CM coordinator shall complete documentation within the EHR according to process developed by KernBHRS. The service will be documented according to the time spend providing the service, and will include the appropriate code below:

1) R82.998: positive urine test for stimulants

2) Z71.51: negative urine test for stimulants

j) Urine Drug Testing

1) During each visit, the CM coordinator will collect a urine sample from the participating member. The CM coordinator shall test the sample for stimulants, including cocaine, amphetamine and methamphetamine, as well as for opiates and oxycodone. The purpose of testing for opiates and oxycodone is to assess relative risk of exposure to fentanyl; this is based on the concept that people who use multiple categories of substances have a greater potential to accidentally ingest fentanyl than people who use a single substance due to the likelihood of additional drug sources. The tests for opiates and oxycodone, even if positive, shall not impact the member's ability to receive an incentive; however, coaching should be done and the clinical need for induction of evidence-based treatment for opioid use disorder assessed if a member tests positive for opioids. In addition, the CM coordinator shall discuss the risks associated with fentanyl; harm reduction safety strategies, including the use of fentanyl test strips, and ensure the member has access to naloxone and knows how it is used.

2) To receive Medi-Cal reimbursement for CM, Contractor shall hold a Clinical Laboratory Improvement Amendments (CLIA) "waived test" certification and be registered with the California Department of Public Health (CDPH) (or be accredited by an approved accreditation body).

3) Each UDT must be performed in accordance with the manufacturer's instructions for the test, and Contractor must ensure that waived testing personnel meet facility- defined minimum requirements and have records of training and competency assessment.

4) Contractor shall use appropriate precautions to avoid tampering with UDT specimens, including the following: requiring members to leave personal possessions (e.g., backpack, purse, items in pockets) in a secure location outside of the restroom; requiring members to thoroughly wash hands or use hand sanitizer prior to entering the restroom, including between fingers and under nails; turning off access to hot water in the restroom (or turning off the water faucet altogether, and requiring hand-washing outside of the restroom); and adding bluing agent to the toilet. Each test must be accompanied by reliability measures,

including temperature, creatinine, and pH level.

5) Four UDTs that meet program specifications, as listed in Table 2. All products listed met the following minimum requirements:

a. Cut-offs for Amphetamine (500 ng/ml), Cocaine (150 ng/ml), Methamphetamine (500 ng/ml), Opiate (300 ng/ml), and Oxycodone (100 ng/ml)

b. Specimen validity measures (temperature, pH, and creatinine)

6) CLIA waived by the Food and Drug Administration (FDA), and therefore meet at least one of three criteria:

a. Cleared by the FDA for home use; OR

b. Employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; OR

c. Pose no reasonable risk of harm to the patient if the test is performed incorrectly.

7) Cost per test is reasonable.

8) CLIA approved FDA list may be obtained at:
https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm

9) Contractor may request for an existing UDT product to be evaluated and approved for use in the Recovery Incentives Program by notifying KernBHRS SOC designee of intent to make this request and submitting the request to DHCS to the following email CountySupport@dhcs.ca.gov including the following information to:

a. Package Insert

b. Cut-offs for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone

c. Cross-Reactivity List for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone (if applicable)

d. Info on specimen validity (if the cup includes this or not): Temperature strip, pH, Creatinine

e. Certification: CLIA-Waived and/or FDA approved

10) DHCS will review requests submitted by Contractor for an alternative UDT and either approve or deny the request for an alternative UDT. Contractor cannot receive reimbursement for CM unless this test has been approved by DHCS.

Table 2 Recovery Incentives Program Approved UDTs						
Company	**Product Name**	**Required Tests**	**Additional Tests Included in Standard Cup**	**General Cost Estimate For Standard Cup (as of 6/15/22)**	**Company Website**	**Contact Information**
Abbott	iScreen Urine Test DX Drug Screen Tox Cup	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, FYL, MDMA, MTD, PCP, TCA, THC	$3.95 per cup; $98.75 per box of 25.	https://www.toxicology.abbott/us/en/products/iscreen-urine-test-dx-drug-screen-tox-cup.html	Telephone: (707) 570-4479 Email: megan.guerrero@abbott.com
CLIA c.	12 Panel IDTC Cups II with Adulterants	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, MDMA, MTD, PCP, TCA, THC	$4.99 per cup; around $124.75 per box of 25.	https://cliawaived. com/cliawaived- inc-idtc-12-panel- cup-with- adulterants.html	Telephone: 858-481-5031 Email: info@cliawaived.com
CLIA c.	14 Panel IDTC II	Amphetamine, Cocaine, Methamphetamine, Opiate,	BAR, BUP, BZO, EDDP,	$4.50 per cup; round	https://cliawaived. com/cliawaived- inc-14-panel-idtc- ii.html	Telephone: 858-481-5031 Email: info@cliawaived.com

		Oxycodone	MDMA, MTD, PCP, TCA, THC	$112.50 per box of 25.		
CLIAWaive Inc.	13 Panel Cup CLIAWaived Cup with Fentanyl and Adulterants - CLIAWaived for Fentanyl Testing!	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP 10, BZO, FEN 5, FYL, MDMA 500, MTD, PCP, THC 50 + CRE, pH	$5.50 per test; $137.50 per box of 25.	https://cliawaived.com/chemtron-13-panel-cup-w-adulterants-cliawaived-for-fentanyl-testing.html	Telephone: (858) 481-5031 Email: info@cliawaived.com
CLIAWaive nc.	CLIAwaived, Inc. Rapid Test Cup "RTC" + Fentanyl*	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BUP, BAR, BZO, MDMA, MTD, PCP, TCA, THC, FYL	$3.99 per test; $99.75 per box of 25.	https://www.cliawaived.com/cliawaived-inc-rapid-test-cup-rtc-fentanyl.html	Telephone: (858) 481-5031 Email: info@cliawaived.com

This test detects the presence of the drug (fentanyl), not its metabolites. Therefore, a positive test indicates exposure to fentanyl, but not necessarily use. An individual who tests positive for fentanyl with this test should be advised that they have been exposed and offered an assessment for medication for addiction treatment as appropriate.

Lochness	Multi-Drug One Step Cup II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, BUP, MDMA, EDDP, KET, THC, MTD, MDPM, PCP, PPX, TRA, TCA	$5.40 per cup.	https://www.lochn essmedical.com/ Product/Cups/169 70	General Inquiries: 1-888-506-2658 info@lochnessmedical.com Orders: orders@lochnessmedical.com Support: support@lochnessmedical.com
Premier	Bio-Cup 12-Drug Panel Drug Test	Amphetamine, Cocaine, Methamphetamine mine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC	$2.50-$3.00 per cup; around $68.75 per box of 25.	https://premierbiot ech.com/innovation/rapid-testing/urine- testing/premier-bio-cup/	Product Questions: 888-686-9909 Laboratory Questions: 855-718-6917
Premier	14 Panel CLIA Waived Urine Test Cup	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC, FYL, TCA, TML	$4.95 per test; $123.75 per box of 25 tests.	https://innovation.premierbiotech.com/rapid-testing/clia-waived/	Telephone: Product Questions: (888) 686-9909 Laboratory Questions: (855) 718-6917

K) Incentive Delivery

1) Overview: Upon learning the results of the UDT, the CM coordinator must inform the member and enter the results into a secure Incentive Manager program that includes strict safeguards against fraud and abuse. CM staff shall not play any role in calculating or determining the appropriate size of the incentive payment but shall follow the algorithm in the Incentive Manager program exactly. The Incentive Manager program shall compute the appropriate incentive amount earned according to the protocol detailed above. The incentive amount shall be delivered immediately to participating members in the format of an e-mail, hard copy, refillable gift card, or other mechanism as approved by DHCS.

2) Incentive Calculations: The Incentive Manager shall automatically calculate the appropriate incentive amount based on the UDT results with adjustments for the escalating value, re-set and recovery features as described in Section E.3 above. Upon each visit, the CM coordinator shall enter the results of the UDT into the Incentive Manager program, and the program will report the appropriate incentive amount, per the protocol. A positive test for stimulants shall result in the participating member receiving no incentive, along with encouraging coaching from the CM coordinator. A negative test for stimulants shall result in an incentive amount as indicated by the Incentive Manager program, considering escalations and resets.

3) After the incentive amount is determined, the Incentive Manager program shall disburse the incentive and shall track all incentives awarded to all participating members, including the CM staff who conducted the visit, the format of the incentive provided to the member, the date the incentive was distributed and the amount of the incentive.

4) Participating members shall receive incentives in a format approved by DHCS to which the Incentive Manager will make deposits upon entry of stimulant-negative UDT results. Restrictions shall be placed on the incentives so they cannot be used to purchase cannabis, tobacco, alcohol or lottery tickets.

l) Billing and Reimbursement

1) Contractor shall bill for each CM visit, similarly to billing for any other DMC-ODS service. Costs are bundled for each single member visit to a CM coordinator and are billed in 15-minute increments, which include:

a. CM coordinator time: pre-, during, and post-visit with the member

b. Supervision

c. Indirect overhead

d. Costs of purchasing urine drug test cups and testing strips.

2) SmartCare Procedures and diagnosis codes are as follows:

a. Procedure Code: Alcohol and/or Drug Services, brief intervention. For negative test results, use diagnosis code Z71.51: This service describes work associated with the Recovery Incentives Contingency Management pilot program in DMC-ODS outpatient programs in Kern County. The service can be performed by an LPHA, Registered or Certified SUD Counselors, Certified Peer Support Specialists, Other trained staff under supervision of an LPHA.

b. This service includes contingency management services to adults and youth with stimulant use disorders, which involve collecting drug urine tests and determining the presence or absence of drugs like cocaine, methamphetamine and other amphetamines. If the result of the drug test is negative for stimulants, the participant will be given a monetary incentive according to program policy. This service also includes preparation for the appointment, conducting the test, providing result and incentive, and providing appropriate SUD interventions based on the staff's scope of practice.

c. Procedure Code: Alcohol and/or Drug Services, brief intervention. For positive test results, use diagnosis code R82.998: This service describes work associated with the Recovery Incentives Contingency Management pilot program in DMC-ODS outpatient programs in Kern County. The service can be performed by an LPHA, Registered or Certified SUD Counselors, Certified Peer Support Specialists, Other trained staff under supervision of an LPHA. This service includes contingency management services to adults and youth with stimulant use disorders, which involve collecting drug urine tests and determining the presence or absence of drugs like cocaine, methamphetamine and other amphetamines. If the result of the drug test is positive for stimulants, the participant will not be given a monetary incentive according to program policy. This service also includes preparation for the appointment, conducting the test, providing results and incentive and providing appropriate SUD interventions based on the staff's scope of practice.

m) Coordination Between Providers

1) Resolving Multiple Registrations: When it is determined that a member is actively receiving CM at one or more providers simultaneously, then Contractor will confer with the other provider(s) to determine which provider will assume treatment responsibility for the individual. In the medical record, an inquiring program shall document the names of each program contacted, the date contacted, the time of the contact (if made by telephone), the name of program staff contacted, and the results of the contact.

2) The provider that agrees to accept sole responsibility will provide CM services to the member. All other providers shall immediately cease providing CM services, discharge the member, and document in the medical record the reason for the discharge. Within 72 hours of the discharge the former providers must give the program assuming treatment responsibility written documentation of the discharge and send written notification to the DMC-ODS county(ies) with whom the providers are contracted of the circumstances involving the discharge. Within 72 hours of agreeing to accept sole responsibility for treatment, the provider that assumes sole

responsibility must send written notification to KernBHRS SOC Administrator or designee. KernBHRS will document and maintain records of duplicative CM service provision and make available such information to DHCS upon request.

3) Inter-County Transfers: During the process of an inter-county transfer, in situations where the member resides in Kern County but the County of Responsibility, as recorded in the DHCS Medi-Cal Eligibility Determination System (MEDS), is another county, Contractor will conduct the screening/assessment and admit the member for medically necessary services while the inter-county transfer process is underway to update the County of Responsibility field in MEDS. Contractor cannot delay admission or the provision of medically necessary DMC-ODS services, including CM services, to members who reside in Kern based on the County of Responsibility being another county.

4) As described in BHIN 21-032, the claim adjudication system for DMC-ODS and DMC services allows the county submitting the claim to be either the member's County of Residence or the member's County of Responsibility as recorded in MEDS. The County of Residence may submit claims and receive payment for DMC-ODS and DMC services so long as the inter-county transfer has been initiated by the member and all other applicable requirements set forth in BHIN 21-032 are met. If Inter-County transfer has not been initiated, Contractor shall assist member in connecting with the Department of Human Services to begin the Inter-County transfer process before providing CM services.

5) Courtesy Services for Temporary Travel: In situations where a member receiving CM services from Contractor and temporarily travels to another DMC-ODS county that also participates in the Recovery Incentives Program, and the member is unable to attend scheduled CM service appointments during their travel, the DMC-ODS County of Responsibility, KernBHRS, must reimburse CM services that an out-of-county DMC-ODS provider participating in the Recovery Incentives Program delivers to the member.

6) The Contractor must provide a courtesy CM service order form to the out-of-county DMC-ODS CM service provider signed by the medical director or program physician and provide a copy to the KernBHRS SOC Administrator or designee. The order form must specify the member's last contact with the local CM coordinator, the number of weeks of participation in the protocol, interval of UDTs, and any other special instructions consistent with the guidelines for CM services issued within this BHIN.

viii. Oversight, Monitoring, Fidelity Reviews, and Reporting

a) Oversight: KernBHRS is responsible for administering CM in accordance with DHCS policies and rules. DHCS expects KernBHRS to oversee the CM benefit as part of their DMC-ODS oversight capabilities. KernBHRS will oversee Contractor to ensure the quality and appropriateness of service delivery.

b) Monitoring:

1) Contractor or designee responsible for overseeing the use of organizational

funds (e.g., chief financial officer or their designee), shall conduct a monthly audit of the incentive delivery functions including the software calculations and incentive distribution records of the organization. Contractor must develop and implement a policy consistent with this requirement. Audit results must be made available to KernBHRS or DHCS upon request. KernBHRS will receive data from the Incentive Manager on a monthly basis that will include reports regarding Contractor's:

a. Utilization of CM services.

b. UDTs outcomes (i.e., positive and negative UDT results).

c. Completion rates of CM.

d. Total rewards.

2) KernBHRS shall review these data elements on a monthly basis to monitor utilization of CM services. KernBHRS will meet with Recovery Incentives Program on a quarterly basis to review data. KernBHRS will identify if Contractor would benefit from technical assistance to address issues regarding utilization or quality and refer Contractor for needed technical assistance to the state's contracted trainer and technical advisor based on KernBHRS' oversight efforts.

KernBHRS shall report to DHCS oversight activities in quarterly progress reports. Such reporting shall include the following:

a. Enrollment information to include the number of DMC-ODS members served in the Recovery Incentives Program.

b. Summary of operational or policy development issues, complaints, grievances, and appeals related to the Recovery Incentives Program.
c. Enrollment information in the Recovery Incentives Program for Contractor.

3) KernBHRS shall be responsible for monitoring Contractor to ensure compliance with state and federal law and contractual obligations. KernBHRS monitoring processes shall comply with:

a. State and federal law;

b. Medicaid guidance including the CalAIM 1915b and 1115 Waivers and the Medicaid State Plan;

c. CM protocol and other requirements as specified in this BHIN, and other relevant regulatory guidance documents including the DMC-ODS IA; and

d. Contractor agreement.

4) Monitoring activities shall include onsite visits, video meetings, and/or desk reviews. DHCS will provide an audit tool for KernBHRS to monitor Contractor. DHCS will train KernBHRS in the use of the audit tools.

C. Fidelity Reviews

1) Contractor is required to participate in fidelity reviews to determine adherence to the CM protocol. Fidelity reviews will be facilitated by the state's contracted trainer and technical advisor as part of ongoing training and technical assistance. Contractor will participate in two fidelity reviews within the first 6 months of implementation of CM and then once every 6 months thereafter.

2) Fidelity reviews will include a cross-check of incentives delivered to members with data in the incentive distribution database. The fidelity review shall also ensure that the Contractor's total amounts paid for incentives provided match UDT results.

3) In coordination with the state's trainer and technical advisor, KernBHRS will participate in fidelity reviews to ensure the provision of CM consistent with the clinical protocols described in this guidance and ensure that client record reviews are conducted for Contractor to evaluate assessment and treatment activities and confirm alignment between assessment information, ASAM criteria, level of care determinations and CM services provided. Contractor will receive support from KernBHRS and the State's training and technical advisor to address any deficiencies. A corrective action plan may be implemented for issues identified during reviews and any follow-up action identified in these plans will be monitored by the county. The participation will support a potential future transition of fidelity reviews from the state's contracted trainer and technical advisor to KernBHRS.

d) Reporting requirements

1) Evaluation: Contractor is subject to participate in surveys and interviews, as requested by KernBHRS and DHCS.

2) Quarterly Reporting: Contractors shall be responsible for complying with any reporting needs related to CM services.

3) Final Report: Contractor may be subject to submit a brief final report regarding the CM to KernBHRS no later than 60 days after the end of the CM pilot agreement.

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

EXHIBIT A-2 DESCRIPTION OF STANDARDS AND SERVICES

PENAL CODE 1000 DRUG DIVERSION PROGRAM

I. INTRODUCTION

A. Purpose

These Penal Code 1000 ("PC 1000") standards of service ("Standards") for the Drug Diversion Program provide KernBHRS, the Courts, the Kern County Probation Department, PC 1000 Contractor, and clients with the minimum requirements and procedures for the successful operation and completion of the PC 1000 program.

B. PC 1000 Drug Diversion Program Goals

The goals of the PC 1000 program include, but are not limited to, the following:

1. Increase clients' understanding of the addiction process and the negative impacts associated with the abuse of drugs and alcohol;

2. Create positive changes in clients' attitudes and behaviors that will lead to a reduction in drug and alcohol abuse;

3. Improve clients' social and personal coping skills;

4. Create an environment for change in which responsible decision-making and viable lifestyle alternatives are acceptable; and

5. Assist and encourage clients to explore healthy lifestyles that promote responsible use of alcohol and the non-use of illicit drugs.

C. Program Eligibility

When a defendant is deemed eligible for drug diversion through the court process, the court may suspend criminal proceedings and refer the defendant to Contractor. Defendants are eligible if all the following requirements are met:

1. There are no convictions for a prior offense involving controlled substances;

2. The current charge does not involve a crime of violence or threatened violence;

3. There is no evidence of a violation relating to narcotics or other restricted dangerous drugs other than a violation of the section listed in PC 1000(a).

4. There is no record of probation or parole being revoked;

5. There is no record of participation in a diversion program within the last five (5) years; and

6. There is no felony conviction within the last five (5) years.

II. GENERAL ADMINISTRATION

A. Application of Standards

These Standards apply to Contractor and clients receiving PC 1000 Diversion Program services from Contractor.

B. Authorities Cited

1. Chapter 2.5, Title 6, Section 1000 of the California Penal Code.

2. Division 10, Chapter 6, Article 5, Paragraph 11357(b) of the California Health and Safety Code.

3.42 CFR Sections 2.1-2.67(1).

C. KernBHRS Responsibilities

The County Alcohol and Drug Program Administrator shall:

1. Develop Contractor PC 1000 Diversion Program certification standards and procedures to ensure programmatic and fiscal integrity of PC 1000 programs;

2. Approve, renew, deny, or revoke Contractor certification;

3. At the court's request, review non-certified programs to determine their credibility and effectiveness to provide PC 1000 program services at no cost to the clients;

4. Recommend programs for approval to the County Board of Supervisors;

5. Develop a curriculum for the PC 1000 Drug Diversion Program, and train Contractor in its use and application;

6. Collaborate with Contractor, the courts, the Probation Department, and other interested parties to maintain quality assurance (program effectiveness and efficiency) in the PC 1000 Program and to develop on-going measures of program effectiveness;

7. Review and approve PC 1000 Program client fee schedules;

8. Monitor program performance and compliance with Standards through program financial information and client data;

9. Ensure that Contractor remains self-sufficient and funded entirely through client fees for the PC 1000 Diversion Program;

10. Establish a mechanism for Contractor to reimburse County costs incurred pursuant to these Standards;

11. Ensure program quality for all clients (i.e., women, disabled, non-English speaking, and other special populations);

12. Amend the Standards as needed based on quality reviews, service data, Contractor's needs, and court needs; and

13. Provide copies of the Standards to Contractor, the courts, district attorney, public defender, Probation Department, and all other interested parties.

.

D. Contractor Responsibilities

Contractor shall:

1. Operate and maintain Contractor PC 1000 Diversion Program services in compliance with these Standards.

2. Ensure fiscal integrity and maintain program costs within the client fee system.

3. Hire, train, and retain qualified staff to process enrollments, collect fees, conduct court liaison activities, provide required client services, and perform daily operational activities.

4. Provide the County Alcohol and Drug Program Administrator or designee access to all Contractor program and financial records to conduct program monitoring and evaluation. Access shall not conflict with any local, state, or federal confidentiality regulations.

5. Accept all referrals from the courts and Probation Department, except in cases in which the safety of the program staff or other clients may be in jeopardy.

6. Provide timely and factual reports to the Probation Department on client's status, according to the designated requirements.

7. Maintain a KernBHRS-approved annual program expenditure and revenue budget.

8. Develop and implement on-going quality control procedures to ensure that program resources are maximized and that client and support servicescomply with these Standards.

9. Provide a payment schedule for those who need financial assistance.

10. Maintain data collection according to KernBHRS requirements.

11. Post the name and telephone number of the County Alcohol and Drug Program Administrator.

E. Probation Department Responsibilities

The Probation Department shall:

1. After the court has granted the request for diversion, refer the client to Contractor.

2. Reschedule drug screening tests as necessary.

3. Report to the courts the client's performance and progress in Contractor's diversion program, and the final disposition of the client at the completion of the program.

III. CONTRACTOR CERTIFICATION OF PC 1000 PROGRAM

A. Certification Requirements

1. KernBHRS shall develop and implement a program certification process based on these Standards.

2. Contractor's PC 1000 program(s) shall be certified for a period of three (3) years, unless Contractor fails to meet these standards, and certification is revoked.

B. Contractor Eligibility

1. Contractor shall have concurrent certification to provide outpatient drug free counseling from the California Department of Health Care Services (DHCS) to be eligible to receive certification as a PC 1000 Drug Diversion Program Contractor.

2. Contractor shall be selected and approved by the KernBHRS Substance Use Disorder System of Care to be certified as a PC 1000 program provider.

C. Initial Certification

1. Competitive Selection Process. KernBHRS issues a Request For Proposal (RFP) to competitively select providers for PC 1000 services. KernBHRS may limit the number of contracted providers. More than one (1) service site per Contractor may be allowed. The competitive process is usually conducted every five (5) years, or as approved by the County Board of Supervisors.

2. Application Processes. KernBHRS will follow standard County processes.

D. Administration Fee. Contractor shall pay KernBHRS an administrative fee of five percent (5%) of its gross revenues for KernBHRS costs of Contractor certification, administration, and ongoing monitoring activities.

E. Contractor Monitoring and Evaluation

Contractor agrees to assist KernBHRS in contract compliance reviews, in any special data collection or research, and in the evaluation of program effectiveness.

1. Measurable outcome objectives. Contractor shall maintain and meet measurable outcome objectives to be determined by KernBHRS.

2. Pre- and Post- Knowledge Tests. All clients must complete a pre-test and a post-test prior to beginning Contractor's PC 1000 Drug Diversion program, prior to beginning and completing each program module, and at the conclusion of the program. KernBHRS shall develop and provide the pre- and post-test instruments. These pre- and post-tests will measure changes in the clients' knowledge and attitudes regarding drug and alcohol abuse. Contractor shall administer all the tests, document clients' scores, and make available a written report of results to KernBHRS on a regularly scheduled basis.

3. Annual KernBHRS review of Contractor. County will schedule and conduct annual monitoring

visits to each Contractor. More monitoring visits may be completed if KernBHRS deems necessary. A written report of findings and recommendations will be prepared and forwarded to Contractor for response and corrective action, if needed.

4. Revocation of Certification. KernBHRS reserves the right to revoke or refuse to renew Contractor's PC 1000 Diversion Program certification any time Contractor fails to respond to KernBHRS requests to take corrective action, or the action(s) taken by Contractor are inadequate to resolve program deficiencies. County will provide to Contractor's program director a written notice within ten (10) days of the effective date of the intended action. The program director may, within five (5) days of the date of the notice, request a review of the findings from the KernBHRS director.

IV. PROGRAM STANDARDS

A. Staff Qualifications

1. Contractor's PC 1000 program director shall possess the following minimum experience and education:

a. Two (2) years of experience providing substance use disorder treatment or recovery services;

b. One (1) year of experience supervising personnel; and

c. One (1) year of experience preparing or directing the preparation of budgets or cost reports.

2. Program staff providing education services must be classified as Certified Substance Abuse Counselors or as Entry-Level Substance Abuse Counselors.

a. A Certified Substance Abuse Counselor is a person who holds current drug and/or alcohol counselor certification from one (1) of the certifying bodies recognized by DHCS.

b. An Entry-Level staff is a Registered Substance Abuse Counselor who has completed at a minimum seventy-five (75) percent of the formal Alcohol and Other Drug (AOD) classroom hours of instruction or a bachelor's from an accredited college or university in behavioral science or related field and one hundred sixty (160) supervised hours in a counseling setting.

3. Staff shall reflect, as closely as possible, the demographics of the client population (e.g., age, race, gender, etc.).

4. Contractor shall maintain personnel records for all staff, containing, at a minimum:

a. Name, address, telephone number, position, duties, and date of hire;

b. Résumés, applications, and transcripts that document work experience and education used to meet the requirements of these standards.

c. Dates and topics of training attended since the date of hire; and

d. Any other related documents as required.

B. Staff Requirements

1. Contractor staff shall attend a KernBHRS-sponsored training provided to become familiar with the PC 1000 program curriculum.

2. Contractor staff shall perform their duties in an ethical manner at all times.

C. Program Services

1. Program Requirements:

Contractor agrees to deliver services as follows:

a. One (1) hour of orientation and enrollment, including a brief substance abuse history, other intake paperwork and a pre-test;

b. Eighteen (18) hours of program services, in twelve (12) ninety (90) minute, non-sequential sessions, including:

i) 1.5 hours of education on the effects of alcohol;

ii) 3 hours of education on the attitudes created by drug and alcohol use;

iii) 4.5 hours of Skill Number 1, Goal Setting Skills Development Introduction, Practice and Mastery;

iv) 4.5 hours of Skill Number 2, Communication Skills Development Introduction, Practice and Mastery; and

v) 4.5 hours of Skill Number 3, Coping Skills Development Introduction, Practice and Mastery.

c. Twelve (12) hours of Advanced Peer Support, in twelve (12) sixty (60) minute sessions, held no more than once each week for twelve (12) weeks.

d. Monitor the client's compliance with the random drug testing program (including completion of three (3) drug screening tests per client), and reports the screening results to the Probation Department.

e. Monitor client attendance at a minimum of twenty-four (24) hours of self-help meetings (self-help meetings must be focused on alcohol and/or drug related issues, such as AA, NA, or CA).

f. Ensure that any classroom or group discussion other than didactic or lectures does not exceed fifteen (15) persons.

g. Offer a payment schedule for those who need financial assistance.

h. Provide service delivery that is sensitive to the cultural, linguistic and special needs of clients.

2. Client Enrollment

a. Contractor may enroll only those individuals specifically referred to its program. Transfers among programs will, however, be considered acceptable.

b. Clients shall be enrolled by the date specified by the court and the Probation Department.

c. Program orientation must include and explain:

i) Required program services;

ii) Requirements for successful program completion;

iii) Program rules and regulations;

iv) Reasons for dismissal;

v) Grievance process;

vi) Abstinence policy;

vii) Confidentiality policy; and

viii) Fees.

d. Contractor must enroll a client by completing:

i) A brief substance abuse history; and

ii) A client contract, which shall list the services to be provided, all program fees, payment schedule, attendance requirements, other program rules, reasons for dismissal, and grievance procedures.

a) The contract shall be dated and signed by staff and the client.

b) Program staff shall give one copy of the completed contract to the client and retain one copy in the case record.

3. Educational Sessions

a. Contractor shall provide no fewer than eighteen (18) hours of drug and alcohol education services during a three (3) month period.

b. Educational sessions shall be scheduled to reasonably accommodate day/evening client needs.

c. Educational topics listed in Paragraph IV. C. 1. b above may be offered in any order that Contractor deems appropriate. However, skills development education must be provided in the following sequence: Introduction, Practice, and Mastery.

d. Educational sessions should employ adult learning theory strategies and methods to promote maximum learning.

e. Contractor shall document attendance and participation at educational sessions in each client's case record.

4. Drug Testing

a. Each client will be subject to three (3) random drug tests during the program.

b. Each client will be charged a fee of Eighteen Dollars ($18.00) for each test, in addition to the program fees.

c. A suspicious test result may be considered a positive test for drug presence and may be grounds for discharge from the program.

d. A client may be discharged after two (2) suspicious tests.

e. Contractor shall use the National Toxicology Laboratories, Inc. for testing.

5. Referral to Ancillary Services

a. Contractor may refer clients, based on individual needs, to ancillary services, such as family counseling, residential treatment and recovery services, self-help programs, and/or any additional outpatient services. The referral and the reasons for such referral shall be documented in the case file.

b. Contractor shall notify the Probation Department of the referral for ancillary services for follow-up with the client.

6. Client Exit Interview

The Client Exit Interview shall include, but not be limited to, the following:

a. A post-test, using a KernBHRS-approved instrument, which measures changes in client attitudes toward the use of drugs and alcohol;

b. A final report to the Probation Department, noting final disposition of the client at the completion of his or her diversion program; and

c. Completion of the client satisfaction survey.

D. Client Records

1. Organization and Contents

a. Contractor will prepare a case folder containing all relevant program material and documentation for each client. The client record shall include, at a minimum:

i) The referral form from the Probation Department;

ii) A copy of the signed contract between the client and the program;

iii) Copies of the Episode Opening and Registration screens;

iv) A copy of the signed Statement of Confidentiality;

v) A copy of the signed program rules and regulations;

vi) All completed pre- and post-tests, including the attitudinal tests and those for each educational module;

vii) The completed brief screening instrument;

viii) Signed Consents to Release Information;

ix) Documentation of self-help meeting attendance;

x) Copies of progress reports to the Probation Department;

xi) Drug screening test results;

xii) Attendance logs;

xiii) Correspondance;

xiv) Payment records;

xv) Client written notes for each class or session;

xvi) Requests for leaves of absence;

xvii) Discharge Summary;

xviii) Copy of the Certificate of Program Completion;

xix) File checklist; and

xx) Other miscellaneous information.

2. Record Retention

Contractor will maintain client records, including completed copies of all required forms and records for a minimum period of seven (7) years aftercompletion of the program.

3. Confidentiality

Contractor will assure confidentiality of client records and information in accordance with Sections 2.1-2.67 (1); Title 42, CFR.

E. Program Reporting

1. Reporting to the Probation Department

a. Contractor shall report to the Probation Department, within ten (10) working days, the following information:

i) Failure to report to the program for enrollment, dismissal from the program, or failure to complete the program; and the reason(s), including documented violations; and

ii) Successful completion of the program requirements.

b. Contractor shall submit to the Probation Department on a monthly basis, a progress report on each client, including the following information:

i) Attendance, including excused and unexcused absences;

ii) Results of drug screening tests, including the date of the test and, if positive, the drugs identified as present in the screening; and

iii) Other information necessary.

c. Client failures to appear for drug screening shall be reported to the Probation Department immediately upon Contractor receipt of the information. The Probation Department shall determine the necessity of rescheduling the drug screening test.

2. Standard Reports to the KernBHRS Substance Use Disorder System of Care

a. Contractor shall:

i) Submit program admissions, discharges, and completions on a monthly basis;

ii) Submit the results of pre- and post-tests, including attitudinal and module tests, on a monthly basis;

iii) Notify KernBHRS within twenty-four (24) hours of any unusual occurrences, according to Policy 11.1.1;

iv) Submit annual financial reports in the format requested by the KernBHRS Substance Use Disorder System of Care;

v) Submit monthly financial data to document and accompany the amount of the KernBHRS administrative fee;

vi) Submit client data; and

vii) Submit any other reports as required.

V. CLIENT STANDARDS

A. Alcohol and Other Drug Use Policy

Clients shall agree to totally abstain from the use of alcohol and other drugs during program attendance.

B. Client Attendance

1. Contractor shall require each client to attend all scheduled activities unless the client has been granted an approved leave of absence.

2. No more than five (5) excused absences are allowed. Excused absences may be granted for:

   a. Medical reasons;

   b. Out of town employment;

   c. Family deaths, and

   d. Vacation (allowed only if all prior program obligations have been met).

3. No more than three (3) unexcused absences are allowed.

4. Contractor shall document all excused absences, and their reasons, and unexcused absences in the client's record.

5. Contractor shall require each client to make up all absences before the successful completion of the program. The client must complete each educational meeting topic.

C. Leaves of Absence

1. Leaves of absence may be approved if requested in advance and in writing. The Contractor’s program director may approve a leave of absence, for the following reasons:

   a. Military personnel whose orders or responsibilities require an extended absence;

   b. Clients whose work requires travel for an extended period of time;

   c. Clients who are absent due to their own extended illness or medical treatment, or that of a family member;

   d. Clients who become incarcerated;

   e. Clients with an extreme personal hardship or family emergency. The program shall document in the client’s case record the nature of the personal hardship or family emergency; and

   f. Clients who have requested a leave of absence for a vacation, if the client is in good standing and is current with all his or her program requirements.

2. Prior to the completion of the program, each client will be required to make up all scheduled program activities missed, and to pay all outstanding fees assessed by the program.

3. Any absences that take place without an approved leave of absence will be considered unexcused.

D. Client Program Fees

1. Contractor shall charge a fee of $550 for PC 1000 Diversion Program services unless KernBHRS revises the fee.

a. Contractor may establish an enrollment fee of $70. The balance ($480) is to be collected in installments of $40 per session or $20 per session. If a system for reimbursement is unavailable through the PC 1000 Program Provider, then installments must be collected at $20 per session.

b. The client is responsible to pay for his or her own drug screen conducted by the National Toxicology Laboratories, Inc. No more than three (3) tests will be required during the course of the program, unless the Probation Department orders additional testing.

c. The program may charge a re-instatement fee of Twenty-Five Dollars ($25).

2. The client's payment schedule shall be documented in the client contract signed at enrollment. The program shall amend the contract to reflect any subsequent increase or decrease in the assessed program fee or the payment schedule.

3. Contractor shall refund to the client any program fee paid in advance for a service the program did not provide.

4. Contractor shall allow the client to pay fees on a schedule other than the one cited above, provided that all fees are paid before the client is deemed to have successfully completed the program.

5. Fee exemptions must be granted in cases of program clients' inability to pay.

E. Financial Assessment to Determine Participant's Ability to Pay Program Fees

1. A participant may request a financial assessment be conducted by the program, by completing a "Participant's Request for a FinancialAssessment" form.

2. Contractor shall not deny services to a participant if, based on the results of a financial assessment, the program determines that the participant is unable to pay the full program fee as shown on the standardized payment schedule.

3. Prior to conducting a financial assessment, Contractor shall notify the participant that he/she:

a. Is required to provide documentation of his/her income at the time of the financial assessment interview, and

b. Will be assessed the full program fee, as shown on the standardized payment schedule, if he/she fails to provide documentation of income at the time of the financial assessment interview.

4. Contractor shall consider as income any of the following, when earned or received by the participant or any person legally required to support the participant:

a. Gross wages, salaries, bonuses, commissions, and tips;

b. Compensation for work-related expenses in excess of the actual expense;

c. Net profits from self-employment,

d. Net income from real or personal property;

e. Spousal support;

f. Regular payments from Social Security, retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance including Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), emergency assistance money, non- federally funded general assistance or general relief money payments], educational grants, or training stipends; and

g. Gross personal income as reported on the federal income tax return.

5. Contractor shall require any participant who has requested a financial assessment to provide the following documentation of income at the time of assessment, and monthly thereafter:

a. If the participant provides an award letter from the county welfare department, confirming eligibility for general assistance, the program shall require no further documentation of income for that month.

b. If the participant does not provide a general assistance award letter, Contractor shall require him/her to provide the following documentation at the time of assessment, and monthly thereafter:

i. An award letter from the county welfare department, or other governmental agency, documenting eligibility for other public assistance and indicating the income level on which eligibility was based; or

ii. Pay vouchers or pay stubs documenting salary for the prior two months; or

iii. Income tax returns for the prior calendar year. The licensee may require the participant to provide a transcript or letter from the Internal Revenue Service or the State Franchise Tax Board verifying the income reported on the prior year's tax return.

6. Contractor shall not require documentation of income other than that specified.

F. Reinstatements

1. Clients who leave the program may be reinstated if the return is within ninety (90) days of the date of discharge. At that point, the client may begin services from the point at which he or she left the program.

2. If the return to the program is longer than ninety (90) days, the client must start the program from the beginning, unless the court stipulates otherwise.

3. Contractor may charge a reinstatement fee of Twenty-Five Dollars ($25). The client will be responsible for the remainder of the fees assessed in the original referral to PC 1000 Drug Diversion Program services.

4. If repeat reinstatements are necessary, the client may be charged additional reinstatement fees of Twenty-Five Dollars ($25) for each reinstatement.

G. Inter-program Transfer

1. A client transferring to another PC 1000 program within Kern County must request authorization in writing from the initial program. Theprogram must notify the Probation Department in advance of said transfer.

2. KernBHRS shall report to the receiving program within twenty-one (21) days of cessation of services by the sending program.

3. The following requirements apply to inter-program transfers:

a. The program client must sign an authorization for the sending program to release information to the receiving program;

b. Notice of Transfer shall be provided on County-approved forms to the court of conviction and to the receiving program;

c. The receiving program shall notify the sending program and the court of the client's enrollment or non-enrollment; and

d. In cases of transfers to out of county programs, the receiving program shall be responsible for client fees, as determined by these Standards.

H. Criteria for Successful Program Completion

The minimum requirements and criteria for successful program completion include:

1. Completion of all required program services;

2. Completion of all pre-and post-knowledge tests; and

3. Payment of all fees.

I. Criteria for Unsuccessful Program Completion

1. Two positive or suspicious drug screens;

2. More than three (3) unexcused absences;

3. Violence or threats of violence against program staff or other program clients;

4. Refusal to comply with any program requirement; or

5. Perpetrating a crime on the premises.

J. Client Grievance Process

1. Contractor shall use protocol and forms developed by County for handling client grievances.

2. The client attempts to resolve the matter with his/her primary program staff member.

3. Within five (5) business days of the alleged grievance, if the matter cannot be resolved, the client may bring the matter to the program supervisor.

4. Contractor has five (5) business days to respond, in writing, to the client. A copy shall be sent to KernBHRS.

5. If there is no resolution, the client may appeal to the County Alcohol and Drug Program Administrator, in writing. The Administrator or designee has five (5) business days in which to respond. The Administrator's decision will be considered final.

EXHIBIT B – SAMPLE AGREEMENT FOR PROFESSIONAL SERVICES

NOTE:
THIS IS AN EXCERPT OF A SAMPLE AGREEMENT. THE ACTUAL CONTRACT WILL BE PRESENTED AND DISCUSSED DURING CONTRACT NEGOTIATIONS

AGREEMENT FOR PROFESSIONAL SERVICES

(COUNTY OF KERN – CONTRACTOR NAME)

SUD OUTPATIENT TREATMENT SERVICES

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

WITNESSETH:

WHEREAS:

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

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

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

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

1. TERM

This agreement shall commence on July 1, 2025, and shall remain in effect through June 30, 2026, unless sooner terminated as hereinafter provided.

2. MODIFICATIONS OF AGREEMENT

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

3. STANDARDS OF SERVICE

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

B. Contractor shall comply with all applicable regulations set forth by the California Department of Health Care Services (DHCS) and any other applicable governing bodies. By this reference, those regulations are made a part of this agreement. Additionally, County requires Contractor to provide proof of adherence to specific administrative and ethical principles in order to be eligible to contract with County.

4. COMPENSATION TO CONTRACTOR

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

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

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

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

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

E. County will periodically evaluate Contractor's program costs for the purpose of assessing the reasonableness of County's payments for services provided. Contractor will be provided reasonable notice if additional contractual and/or service delivery issues are to be reviewed. Contractor is expected to prepare necessary reports and other material to adequately explain Contractor's use of

funds as specified in the Funding Schedule of this agreement. County may prescribe specific report formats and data content as deemed necessary at the sole discretion of County.

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

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

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

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

7. Terms of Drug Medi-Cal Organized Delivery System Intergovernmental Agreement.

5. FINANCIAL SOLVENCY

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

6. FINANCIAL AND STATISTICAL RECORDS

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

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

7. MEDICAL RECORDS MANAGEMENT

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

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

8. NOTICES

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

To County:
Behavioral Health and Recovery Services
Attn: Director
PO Box 1000
Bakersfield, CA 93302-1000

cc: Contracts Management

To Contractor:
Contractor
Address
City State Zip Code

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

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

9. MANDATORY MEETINGS

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

10. EXCLUSION REPORTING

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

11. HIPAA/HITECH COMPLIANCE

A. During the term of this agreement, Contractor may receive from County, or may receive or create on behalf of County, certain confidential health or Medi-Cal information ("Protected Health Information" or "PHI"). This PHI is subject to protection under state and federal law, including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws. Contractor represents that it has in place policies and procedures that will adequately safeguard any PHI it receives or creates, and Contractor specifically agrees, on behalf of itself, its subcontractors, and agents, to safeguard and protect the confidentiality of PHI consistent with applicable law, including currently effective provisions of HIPAA, the HITECH Act, and the HIPAA Regulations.

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

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

written evidence that Contractor is in compliance with the HITECH Act and applicable HIPAA Regulations.

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

12. INDEMNIFICATION

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

13. INSURANCE

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

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

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

A. Workers' Compensation and Employers Liability Insurance Requirements:

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

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

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

B. Liability Insurance Requirements:

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

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

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

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

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

01 plus either ISO form CG 20 10 10 01 or CG 20 33 10 01; or (iii) on such other forms which provide coverage at least equal to or better than form CG 20 10 11 85.

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

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

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

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

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

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

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

J. Failure by Contractor to maintain all such insurance in effect at all times required by this agreement shall be a material breach of this agreement by Contractor. County, at its sole option, may terminate this agreement and obtain damages from Contractor resulting from said breach.

Alternatively, County may purchase such required insurance coverage, and without further notice to Contractor, County shall deduct from sums due to Contractor any premiums and associated costs advanced or paid by County for such insurance. If the balance of monies obligated to Contractor pursuant to this agreement is insufficient to reimburse County for the premiums and any associated costs, Contractor agrees to reimburse County for the premiums and pay for all costs associated with the purchase of said insurance. Any failure by County to take this alternative action shall not relieve Contractor of its obligation to obtain and maintain the insurance coverages required by this agreement.

14. POLITICAL-RELIGIOUS ACTIVITY

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

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

15. NO THIRD-PARTY BENEFICIARIES

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

16. AUTHORITY TO BIND COUNTY

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

17. CHOICE OF LAW AND VENUE

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

18. NON-WAIVER

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

remedy available to County under this agreement or by law or in equity despite said forbearance or indulgence.

19. ENFORCEMENT OF REMEDIES

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

20. CAPTIONS AND INTERPRETATION

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

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

21. TIME OF ESSENCE

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

22. COUNTERPARTS

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

23. NON-COLLUSION COVENANT

A. Contractor represents and agrees that it has in no way entered into any contingent fee arrangement with any firm or person concerning the obtaining of this agreement with County. Contractor has not received from County any incentive or special payments, or considerations not related to the provision of services under this agreement.

24. ENTIRE AGREEMENT

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

25. NEGATION OF PARTNERSHIP

A. In the performance of all services under this agreement, Contractor shall be, and acknowledges that Contractor is, in fact and law, an independent contractor and not an agent or employee of

County. Contractor has and retains the right to exercise full supervision and control of the manner and methods of providing services to County under this agreement. Contractor retains full supervision and control over the employment, direction, compensation, and discharge of all persons assisting Contractor in the provision of services under this agreement. With respect to Contractor's employees, if any, Contractor shall be solely responsible for payment of wages, benefits, and other compensation, compliance with all occupational safety, welfare, and civil rights laws, tax withholding and payment of employee taxes, whether federal, state, or local, and compliance with any and all other laws regulating employment.

26. SEVERABILITY

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

27. TERMINATION

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

28. IMMEDIATE TERMINATION

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

29. REQUIRED DOCUMENTS

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

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

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

30. SIGNATURE AUTHORITY

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

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

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

APPROVED AS TO CONTENT: Behavioral Health and Recovery Services	**COUNTY OF KERN** Board of Supervisors
By: ______________________________ Alison Burrowes, MA, LCSW, Director	By: ______________________________ Chairman
APPROVED AS TO FORM: Office of the County Counsel	**CONTRACTOR**
By: ______________________________ Kyle Holmes, Deputy	By: ______________________________ Contractor

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

CONTRACTOR NAME

AGREEMENT FOR PROFESSIONAL SERVICES

(COUNTY OF KERN – CONTRACTOR NAME)

OUTPATIENT SUBSTANCE USE DISORDER TREATMENT SERVICES

Applicable Contract Exhibits Will Be Discussed And Added To The Contract During Contract Negotiations. Sample Exhibit In Your Negotiated Contract May Include:

I. ADDITIONAL ADMINISTRATIVE AND ETHICAL REQUIREMENTS

Contractors shall provide to County on the due date provide by BHRS:

1) Credentials: Copies of appropriate credentials and licenses required to perform the scope of work as delineated in Exhibit "A" entitled **"DESCRIPTION AND STANDARDS OF SERVICES".**

2) Insurance: Certificates of adequate and appropriate insurance as required in the paragraph entitled **"INSURANCE"** of this Agreement.

3) Performance: Written notification within three (3) days of any event, occurrence, or circumstance that will prevent, delay, or otherwise interfere with Contractor's performance under this Agreement including items of a financial or health nature.

II. OUTPATIENT RATE TABLE

SmartCare Procedure code	Service Description	Time	HCPC	Time	CPT	Rate
SUD Screening	Assessment	15 min	H0001	1 unit		
Contingency Management	Recovery Incentives Program only	15 min	H0050			
SUD Crisis Intervention	SUD Crisis Intervention	15 mins	H0007			
Group Counseling	Group Counseling	15 min	H0005			
Discharge Planning	Discharge Planning	15 min	T1007			
Individual Counseling	Individual Counseling	15 min	H0004			
Behavioral Health Prevention Education Service	Peer Service – Group	15 min	H0025			
Self Help/Peer Services	Peer Services – Individual	15 min	H0038			
TCM/ICC	Care Coordination	15 min	T1017			
Comprehensive Community Support Service	Recovery Services only	15 min	H2015			
Psychosocial Rehabilitation Individual	Recovery Services only	15 min	H2017			
Psychosocial Rehabilitation Group	Recovery Services only	15 min	H2017 HQ			

III. BUSINESS ASSOCIATE ADDENDUM

THIS BUSINESS ASSOCIATE ADDENDUM ("Addendum") supplements and is made a part of the agreement ("agreement") by and between the County of Kern ("Covered Entity" or "CE") and ________________________ ("Business Associate" or "BA"). This Addendum is effective as of date first written above (the "Addendum Effective Date").

RECITALS:

A. CE wishes to disclose certain information to BA pursuant to the terms of the agreement, some of which may constitute Protected Health Information ("PHI"), Personal Information ("PI"), or Personally Identifiable Information ("PII") (defined below). For the purpose of this Exhibit, PHI, PI, and PII all refer to confidential information that must be protected.

B. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

IV. PRIVACY AND INFORMATION SECURITY PROVISIONS

This Exhibit is intended to protect the privacy and security of specified Kern Behavioral Health and Recovery Services (County) information that Contractor may access, receive, or transmit under this agreement. County information covered under this Exhibit consists of: (1) Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; (2) Personal Information (PI) as defined under the California Information Practices Act (CIPA), at California Civil Code Section 1798.3; Personal Information may include data provided to the Department by the Social Security Administration; and (3) Personally Identifiable Information (PII); however, to the extent that data is PHI or ePHI and PI or PII, this Exhibit shall apply.

I. Recitals.

A. In addition to the Privacy and Security Rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which defines Protected Health Information (PHI), County is subject to various other legal and contractual requirements with respect to the personal information (PI) and personally identifiable information (PII) it maintains. These include:

1. The California Information Practices Act of 1977 (California Civil Code §§ 1798 et seq.).

2. The Agreement between the Social Security Administration (SSA) and the Department of Health Care Services (DHCS), known as the Information Exchange Agreement (IEA), which incorporates the Computer Matching and Privacy Protection Act Agreement (CMPPS) between the SSA and the California Health and Human Services Agency.

V. PROGRAM INTEGRITY REQUIREMENTS

1. GENERAL REQUIREMENTS

As a condition for receiving payment under a Medi-Cal managed care program, Contractor shall comply with the provisions of 42 CFR §§ 438.602, 438.608, 438.610, 455.1(a)1, 455.104-455.106, 455.434; Social Security Act §§ 1128, 1156, and 1842(j)(2).

2. EXCLUDED PROVIDERS

Contractor shall not knowingly have a relationship with any individual or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in any of such programs by any federal agency or by any department, agency or political subdivision of the state. For purposes of this paragraph, "principal" means an officer, director, owner of any portion of the entity, partner, key employee, subcontractor, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Contractor operations. Contractor shall be required to submit a Disclosure of Ownership and Control Interest Statement during the initial contracting, re-contracting and/or recredentialing process or upon request by County.

3. SERVICE VERIFICATION.

Pursuant to 42 C.F.R. § 438.608(a)(5), Contractor shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered, were received by beneficiaries, and the application of such verification processes on a regular basis.

4. DISCLOSURES OWNERSHIP CONTROL INTEREST STATEMENT

A. Contractor agrees to furnish County with the names of its officers, owners, stockholders owning more than five percent (5%) of its stock, and major creditors holding more than five percent (5%) of the debt of Contractor. This information shall become public record on file with the U.S. Department of Health and Human Services.

V. CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS

KernBHRS will establish and conduct a provider Credentialing Program for credentialing and re-credentialing Contractor's network treatment providers. Contractor shall agree to comply with the terms set forth herein.

Contractor shall adhere to the California Department of Health Care Services' (DHCS) statewide uniform provider credentialing and re-credentialing requirements, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214.

KernBHRS will ensure that Contractor and its employees, agents, or subcontractors are qualified in accordance with current legal, professional, and technical standards, and are appropriately licensed, registered, waivered, and/or certified.

[END OF EXCERPT OF SAMPLE AGREEMENT & EXHIBITS]

EXHIBIT C – FREE SPEECH POLICY

Kern County Administrative Bulletin

ADMINISTRATIVE BULLETIN NO. 19

Issued: January 23, 2024

SUBJECT: FREE SPEECH POLICY

Purpose

The purpose of this Free Speech Policy is to inform all employees, employment applicants, and contractors of their constitutional rights to free speech, to petition the government for redress of grievances, to instruct representatives, and to freely associate and assemble. Unlawful discrimination based on the exercise of these rights is unacceptable and incompatible with the County's standards, as well as being a violation of the law. This Free Speech Policy also establishes the complaint and investigation procedure for alleged violations of these rights.

First Amendment Rights

Every County employee, employment applicant, and contractor has a constitutional right to free speech, to petition the government for redress of grievances, to instruct representatives, and to freely associate and assemble. [1] For simplicity, this policy shall refer to such rights as "First Amendment Rights."

Every County employee, employment applicant, and contractor shall be free from any unlawful discrimination or retaliation by the County of Kern for exercising their First Amendment Rights while employed, while seeking employment, or while doing or seeking to do business for or with the County.

Free Speech Policy

The County of Kem remains committed to creating a professional environment in which the First Amendment Rights of all County employees, employment applicants, and contractors are protected.

It is a violation of the Constitutions of the United States and California for the County to unlawfully discriminate against County employees, employment applicants, or contractors because they exercised their First Amendment Rights.

Every County employee, and other person acting on behalf of the County, including members of the Board of Supervisors, is prohibited from unlawfully discriminating against, harassing, or retaliating against an employee, employment applicant, or contractor because the employee, employment applicant, or

[1] California Constitution, article I, sections 2(a) and 3(a); U.S. Constitution, amend. I.

contractor exercised their First Amendment Rights, or because they filed a complaint or participated in an investigation under this Free Speech Policy.

All County employees and other persons acting on behalf of the County, including members of the Board of Supervisors, shall uphold and abide by this Free Speech Policy by cooperating fully in any investigation of a complaint of unlawful discrimination, harassment, or retaliation under this Free Speech Policy.

Persons in positions of authority, including managers and supervisors, shall act immediately on potential violations of this Free Speech Policy. They are responsible for knowing and enforcing this Policy and creating and maintaining a workplace free of discrimination, harassment, and retaliation, and should address potential problems before they become serious.

This Free Speech Policy applies at every level of the County and to every aspect of the workplace environment, including but not limited to, County events that occur outside of the physical workplace.

This Free Speech Policy shall be posted on the Kem County websites and in designated physical locations, and shall be attached to all County-issued Requests for Proposals (RFPs) and other solicitations for contract or grant proposals, County contracting forms and templates, and relevant notices to employees, employment applicants, and contractors.

Examples of unlawful discrimination:

- A department head recommends that a contract not be renewed because the contractor is politically active, regardless of their political position.

- A supervisor declines to recommend a supervisee for a promotion, or assigns a supervisee to less favorable job duties or to a less favorable location, because of the supervisee's union activity.

- A manager gives a supervisee poor job evaluations because the manager does not agree with their supervisee's political views.

- A county decision-maker declines to award a contract to provide social services to a particular community based organization because that organization actively campaigns for a particular bill or social movement.

- A county decision maker stops communicating with a potential contractor about a contract because the contractor has threatened to file lawsuit against the County in an unrelated case.

The California and U.S. Constitutions also provide specific First Amendment protection for County elected officials and other persons acting on behalf of the County, including volunteers and interns. This policy does not address such persons' rights.

<u>Complaint and Investigation Procedure</u>

Each employee, employment applicant, or contractor who believes that they have experienced unlawful discrimination or harassment described in this Policy may file a written complaint setting forth the specific facts and evidence supporting the complaint with the County Complaint Coordinator (see below). Such complaints shall be promptly forwarded to the Free Speech Retained Expert (see below). The complainant

shall provide all documentary evidence, names of potential witnesses, and any other information believed by the complainant to be relevant to the complaint.

The County Complaint Coordinator shall initiate a formal investigation of the allegations in the complaint, interview all witnesses to the incident giving rise to the complaint (including the complainant and the person(s) against whom the complaint is directed), and issue written findings as to the merits of the complaint and the remedies that should be implemented to resolve the complaint under existing County ordinances, policies, and procedures. The County Complaint Coordinator shall have a period of not more than 75 business days from receipt of the complaint to conduct the investigation and to issue appropriate draft findings and recommended remedies. The 75-day time period may be extended due to the unavailability of a material witness, or with the written agreement of the complainant.

The County Complaint Coordinator shall provide the draft findings and recommended remedies to the Free Speech Retained Expert for review and approval. The County Complaint Coordinator shall also provide the Free Speech Retained Expert with a copy of the complaint, all information and documentary evidence provided by the complainant, all witness interview materials and documents provided by witnesses, and all information and documentary evidence developed by the County Complaint Coordinator in conducting the investigation.

In the event that the Free Speech Retained Expert does not approve the County Complaint Coordinator's draft findings and recommended remedies, the Free Speech Retained Expert shall prepare a written explanation of the reasons for non-approval. The Free Speech Retained Expert and County Complaint Coordinator shall meet and confer to resolve any disagreement or deficiencies, and both parties shall state their positions in writing. The County Complaint Coordinator shall then take all necessary steps to correct any deficiencies and re-submit the draft findings and recommended remedies to the Free Speech Retained Expert for review and approval.

In the case of any complaints in which there is an appearance of bias, conflict of interest, or insufficient independence with regard to the handling of the complaint by the County Complaint Coordinator, the Backup Complaint Coordinator (see below) shall conduct the investigation, and the Free Speech Retained Expert shall review and approve in the same manner as any investigation conducted by the County Complaint Coordinator.

The Free Speech Retained Expert shall conduct the investigation if both the Complaint Coordinator and the Backup Complaint Coordinator are conflicted. The County shall implement the Free Speech Retained Expert's findings and remedies.

Department heads shall be responsible for ensuring that all new employees and contract staff in their department receive a copy of this policy and sign an acknowledgment which shall be retained in the employee's personnel file (or a similar file for contract staff). In addition, department heads shall ensure that, on an annual basis, each employee in their department receives a copy of this policy and that an acknowledgment of receipt is contained in each employee's personnel file.

Department heads may establish departmental policies and internal complaint procedures provided that those policies and procedures are consistent with this Policy. Nothing in this Policy shall abrogate any legal evidentiary standards in a court of law.

Complaints Within the Scope of Civil Service Commission Rule 1810.00, et seq.

The Kem County Rules of the Civil Service Commission ("Civil Service Rules") provide a voluntary complaint procedure for some complaints that fall within the scope of this Policy. These Civil Service Rules apply to civil service employees or applicants for civil service employment complaining of unlawful discrimination, harassment, or retaliation based on religious, union, or political affiliation, or due to their participation in a government investigation.

A complainant whose complaint falls within the scope of both the Civil Service Rules and this Policy may choose to file their complaint using the procedure described in the Civil Service Rules, commencing at section 1820.00, or using the procedure otherwise described in this Policy, but not both. If a complainant invokes both procedures for the same complaint, the complainant shall be required to make a written election of which procedure they wish to have apply.

The Free Speech Retained Expert will review all such complaints consistent with the time limitations, procedure, and appellate rights set forth in Civil Service Rule 1820.00. The Free Speech Retained Expert will review and approve findings of fact and recommended remedies issued by the Equal Employment Opportunity Officer.

Under Civil Service Rule 1830.00-1830.02, either the complainant or the County may request a hearing before the Civil Service Commission. The Free Speech Retained Expert does not review the Civil Service Commission's decision for approval but will provide a report to the County and complainant regarding any comments, concerns, or recommendations related to the Commission's final decision, within 60-120 days of that decision.

County Complaint Coordinator: Sarah Gutierrez, Director of Diversity, Equity and Inclusion; (661) 868-3919; gutierrezsa@kerncounty.com

Backup County Complaint Coordinator: Mercedes Perez, Senior Human Resources Specialist; (661) 868-3915; perezmer@kerncounty.com

Free Speech Retained Expert:
Barry McDonald, (310) 506-4668; barry.mcdonald@pepperdine.edu
Apm/AB/AB-19_01-23-2024

By my signature below, I acknowledge that I have received and reviewed this Free Speech Policy (AB19) and I understand that a copy will be placed into my personnel file.

____
Printed Name

______________________________ ______________
Employee Signature Date

APPENDIX I - PROPOSAL CHECKLIST AND OUTLINE

Directions: Please draft the proposal using the format listed below:

Proposal Format

- The length of the proposal should be no longer than 25 - 50 pages.
- Please use complete sentences for each section of the proposal.
- Please Arial font and the font size should be 12.
- Please do not include **Patient Health Information** in this or any other section of your proposal. This will be grounds for immediate disqualification from the RFP process.
- **Please do not submit canned or generic proposals.** (A "canned" submission is one that is being repurposed from a previous proposal. Submission should be specifically written for this RFP.)
- For ease of review and to facilitate evaluation, the Proposals for this project must be organized and presented in the order requested as follows **(no exceptions):**

III. Proposal Contents:

___1. Cover Page:

The Cover Page section should include the following information:

- Request For Proposals For ______________ Services
- Name Of The Organization Submitting The Proposal.
- Name and Title Of The Person Submitting The Proposal

___**1a. Checklist Table:**

Use the Checklist Table below to indicate which region(s) services will be provided in and specify whether the services are for Adults, Adolescents, or both.

Region	Adult	Adolescent	PC 1000	Contingency Management
Arvin				
Bakersfield				
Delano				
Frazier Park				
Lake Isabella				
Lamont				
Ridgecrest				
Taft				
Tehachapi / Mojave				
Wasco				

___**2. Introduction:**

The Introduction section should include the following information:

- Include a letter of introduction about your organization signed by an authorized representative of the firm.

- In your introductory statement please include the following language at the end of your introductory statement.

  "The undersigned certifies that all statements in the Proposal are true and correct; and that any materially false statements contained in this proposal shall entitle Kern County to pursue any and all remedies authorized by law and/or declare any contract made as a result thereof, to be void."

- Please include an email address that we may use to contact your organization.

___**3. Corporate/Agency Profile:**

The Corporate / Agency Profile section should include the following information:

- The legal name, address and telephone number of your company

- The type of entity (sole proprietorship, partnership, or corporation and whether public or private).

- Whether you are a local Kern County vendor as defined in section I.D.2. of this RFP (provide the street address of the local office).

- The name, telephone number, and email of the person(s) in your company authorized to execute the proposed contract.

___4. Organization's Qualifications and Experience

The Organization's Qualifications and Experience should include the following information:

Part I: Headers

This section should include:

- Header #1: The number of staff (key and non-key) involved in providing services

- Header #2: Number of years the organization has been providing services

- Header #3: Skill sets that organization uses in providing services

- Header #4: Contractor licensing, if applicable
- Header #5: Certifications, if applicable

- Header #6: Examples of completed projects

Part II: Financial Statements

This section should include:

- Balance sheet

- Dun & Bradstreet credit rating

Part III: Documentation of Satisfactory Past Performance/References

This section should include:

- Provide a minimum of three (3) reference letters for similar services rendered (must be within the last twelve (12) months on the reference company's letterhead.

- Each reference shall include a current point of contact and a phone number.

- Each reference letter must have all the following information:

    - Date of the original contract
    - End date of the contract
    - Services rendered

- Names, addresses, email and telephone numbers of contact persons within organizations /agencies for whom the services have been provided

Part IV: Similar Services Over The Last Two Years

This section should include:

- Provide a list of all organizations with current contact information including email, to which you have provided similar services over the last two years but are not currently working for.

- Please indicate why you are not currently providing services to said organization(s).

Format Example:

- Name Of The Organization:
- Name Of The Contact:
- Contact’s Email Address:
- Contact's Phone Number:
- Why is your organization no longer providing services to this organization (Keep responses to 2 to 3 sentences):

___5. Credentials/Resumes:

The Credentials / Resumes should include the following information:

Part I: Organizational Chart

This section should include:

An Organizational Chart displaying all the key personnel assigned to the project and/or delivery of services.

Part II: Resumes

This section should include:

Resumes of all key personnel assigned to the project and/or delivery of services as designated in the organizational chart.

Part III: Training Certifications

This section should include:

Training certifications of all key personnel assigned to the project and/or delivery of services as designated in the organizational chart.

Part IV: Summary Of The Statement Of Qualifications

This section should include:

A summary of the statement of qualifications for each key personnel assigned to the project and/or delivery of services, in the organizational chart, to include the following **(2 to 3 single pages):**

- General Experience as it relates to the project and/or delivery of services
- Education as it relates to the project and/or delivery of services
- Training as it relates to the project and/or delivery of services
- Credentials as it relates to the project and/or delivery of services

Part V: Subcontractors and/or Consultant Firms

This section should include:

List subcontractors and/or consultant firms, if any, that you plan to use for this project and their relevant experience.

Format Example:

- Name Of The Subcontractors and/or Consultant firms:
- Contact Name:
- Email Address:
- Phone Number:
- What is their relevant experience as it relates to the RFP's scope of work outlined in Exhibit A – Description and Standards of Service (Keep responses to 2 to 3 sentences):

___6. Project Approach, Work Schedule, Transition Plan and Technology Requirements:

The Project Approach, Work Schedule, Transition Plan and Technology Requirements should include the following information:

Part I: Project Approach:

This section should include:

a. Provide a detailed description of the project approach proposed by your organization to perform all required services as specified in the RFP's scope of work, Exhibit A – Description and Standards Of Services **(250 words).**

b. Provide a detailed description of the methodology proposed by your organization to perform all required services as specified in the RFP's scope of work, Exhibit A – Description and Standards Of Services **(250 words).**

c. Identify the deliverables that will be produced as specified in the RFP's scope of work, Exhibit A – Description and Standards Of Services **(250 words).**

d. Describe the actions that will be performed by your organization in order to comply and meet required benchmarks, performance standards and quality assurance measures **(250 words).**

e. Describe your organization's approach and/or methodology that will be used to address obstructions, constraints, or roadblocks that may occur in providing services **(250 words).**

f. Describe how your organization's Business and Work Environment will assist with the delivery of services as specified in the RFP's scope of work Exhibit A – Description and Standards Of Services **(250 words).**

<u>Part II: Work Schedule:</u>

This section should include:

g. Include specific details with regard to a work schedule which contains an aggressive plan describing how your organization will implement the services as specified in the RFP's scope of work Exhibit A – Description and Standards Of Services **(250 words).**

<u>Part III: Transition Plan:</u>

This section should include:

h. Include specific details with regard to a transition plan (e.g. from an existing provider to new provider) which contains an aggressive schedule that describes how your organization will start up the services as specified in the RFP's scope of work before **July 1, 2026 (250 words).**

<u>Part IV: Technology Requirements:</u>

This section should include:

i. Detail and describe security clearance and information technology requirements that your organization has in place to ensure HIPAA compliance **(250 words).**

j. Specify all software and computer technology (if applicable) that is anticipated to be used in rendering the services as specified in the RFP's scope of work Exhibit A – Description and Standards Of Services. If the Proposal includes the purchase of any software by the BHRS, provide a copy of any software license agreements that BHRS would be required to execute **(250 words).**

___7. Cost of Service:

This section should include

A budget that:

- consists of all of the costs associated with the project, broken down by category of products and services, and all on-going costs for recommended/required products/services such as maintenance.

- includes all expenses that will be charged to the County including but not limited to costs for shipping, insurance, communications, documentation reproduction, travel, taxes, etc.

  Note: Please use a budget template that reflects the abovementioned information. The department does not have a specific template.

___8. Insurance:

This section should include:

A statement from the proposer that the organization will obtain insurance as required in the attached sample agreement.

___9. Additional Information:

This section should include:

- Include any additional information and options that you feel may be advantageous to the County. Label options clearly and specify all costs and fees associated with each option.

- Include any other information you believe to be pertinent but not required.

Note: Attachments & Appendixes must be a part of the proposal and not sent as separate documents.

[END OF THE RFP]