Date: July 10, 2018

To: All Interested Organizations

Subject: Request for Qualifications and Statement of Interest  
RFQ #19-918-004  
Response Design Guidelines for Drug Medi-Cal Organized Delivery System (DMC-ODS)

The County of El Dorado Office of Procurement and Contracts, through its Health and Human Services Agency (also referred to as “County”), is requesting responses from qualified providers for multiple types of services provided through the Drug Medi-Cal Organized Delivery System (DMC-ODS).

This Request for Qualifications (RFQ) defines the scope of services and outlines the requirements that must be met by Respondents interested in providing any of DMC-ODS services, as identified herein. Respondents shall carefully examine the entire RFQ and any addenda thereto, and all related materials and data referenced in the RFQ or otherwise available, and shall become fully aware of the nature and the conditions to be encountered in performing the service. Respondents are advised to read all sections of this RFQ prior to responding to the RFQ. All information provided in response to this RFQ is subject to verification. Misleading and/or inaccurate information shall be grounds for disqualification at any stage in the procurement process.

Thank you for your participation in the RFQ process!

Alex Strudley
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1. Overview

El Dorado County is located in Northern California and is bordered by Sacramento, Placer, Amador and Alpine counties in California, and Douglas County, Nevada. The two (2) incorporated cities in El Dorado County are Placerville and South Lake Tahoe. El Dorado County’s total population as of 2016 is 183,750; the County’s population is projected to reach 194,527 by 2020, a six percent (6%) increase over the next four (4) years.

The California Department of Health Care Services (CDHCS) has established a Drug Medi-Cal Organized Delivery System (DMC-ODS), which provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. This continuum of care enables more local control and accountability, provides administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence based practices in substance abuse treatment, and coordinates with other systems of care. At this time, DMC-ODS is a pilot project being introduced throughout California through counties who choose to participate in the initial implementation; County of El Dorado has submitted an implementation plan, thereby choosing to participate.
The purpose of this RFQ is to solicit eligible organizations that are qualified to provide any of the DMC-ODS services, within the range of services identified in this RFQ. This RFQ process is non-competitive; any qualified contractor capable of meeting the eligibility and services requirements as indicated herein will be selected to negotiate a contract with the County. Selection as a result of this RFQ does not guarantee a contract, but rather recognizes a proposing vendor is qualified to provide services as identified herein and as a result, can begin negotiations for a contract. All contracts resulting from this RFQ process are subject to successful negotiations resulting in mutually agreeable terms, including cost considerations. Respondents should also be aware that all contracts resulting from this RFQ are fully contingent upon approval of the County’s DMC ODS Waiver plan by the California Department of Public Health; approval of this plan may impact the timeliness of any resulting agreements between the County and vendors for services. At this time, it is anticipated the plan will not be approved until the fall of 2018. This RFQ is being conducted in part to identify providers in advance, in the interest of moving forward as soon as possible after the plan is approved.

Respondents are advised that the County will not pay for any information or administrative costs incurred in response to this RFQ; all costs associated with responding to the RFQ will be solely at the respondent’s expense. Not responding to this RFQ does not preclude participation in any future solicitations. Any future solicitations, if released, will be posted on the County website http://edcapps.edcgov.us/contracts/invite.asp. It is the responsibility of the potential respondents to monitor the site for additional information. All information submitted by qualified organizations will be retained by the County.

2. Additional Considerations

Before submitting a response to this RFQ, organizations should be aware all contracts resulting from this RFQ will be subject to the following conditions and standards:

A. Federal funding will comprise a portion of the funds utilized to pay for DMC-ODS Waiver services in the County. As a result the following conditions are applicable:

1) The Facilities and Administration costs (also referred to as indirect costs) associated with services identified in this RFQ are subject to federal limits as defined in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (as defined in Title 2, Subtitle A, Chapter II, Part 200 of the Code of Federal Regulations (CFR)). Respondents should be familiar with said regulations, including but not limited to (as applicable) Appendix IV, which details Indirect (F&A) Cost Identification and Assignment, and Rate Determination for Nonprofit Organizations. Respondents are encouraged to provide a copy of their negotiated Indirect Cost Rate agreement, approved by a cognizant federal entity. Consistent with the requirements of 2 CFR 200.414(f), any non-Federal entity that has never received a negotiated indirect cost rate, may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC), which may be used indefinitely. The indirect cost rate used by the responded should be identified on the DMC-ODS Provider Rate Template (Attachment “D”), consistent with this requirement.
2) DMC providers (as defined in California Welfare and Institutions Code (WIC) Section 14043.1.o), at the time of application, may not be currently under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the CFR, unless the California Department of Health Care (DHCS) Services determines there is good cause to allow enrollment, subject to the provisions of 42 CFR 455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to WIC Section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to WIC Section 14107.11, after which DHCS may collect any overpayment identified through an audit. A provider shall be subject to suspension pursuant to WIC Section 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal Program. A provider will be subject to termination if the provider has an outstanding debt owed to any government entity related to any federal or state health care program that has not been excused by the legal process.

B. DHCS will require the County to ensure DMC providers selected for services within the County have met the requirements established under applicable State and Federal regulations. Consistent with DHCS requirements, the County may only select providers that meet the following:

1) DMC providers must have enrolled with or certified and revalidated their current enrollment with DHCS as a DMC provider under applicable state and federal regulations prior to submitting a response to this RFQ;

2) DMC providers must have been screened in accordance with 42 CFR 455.450(c) as a high categorical risk prior to furnishing services. DHCS has designated all newly enrolling or certifying and revalidating DMC providers as “high risk” in order to meet this requirement. Screening should have taken place during the application or recertification process. As a result, the County may only selected DMC providers who have been screened as “high risk” prior to submitting a response to this RFQ;

3) DMC providers must have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, prior to submitting a response to this RFQ; and

4) DMC providers must have complied with the ownership and control disclosure requirements of 42 CFR 455.104.

Verification that a Respondent has met these requirements is a requirement that should be met through the submission of documentation, as specified in Section 6. Statement of Interest and Response Content, Subsection “C”, Supporting Documents.

C. While not comprehensively detailed in this RFQ, resulting contracts will require respondents to capture and report data necessary to comply with the California Network Adequacy reporting requirements and/or any other requirements specified by the State. Any such reporting requirements will be specified in said agreements and subject to repeated changes as required by the State.
D. Services specified in this RFQ are primarily for the purposes of providing services to Drug Medi-Cal eligible clients. As such, resulting service agreements will require providers to verify client eligibility on a regular, on-going basis in order to ensure services are not provided and billed for ineligible clients. Providers will be required maintain an eligibility denial rate of fifteen percent (15%) or less, or face possibility of adverse action including but not limited to contract termination. The County will track a claim denial rate for each DMC-ODS provider to ensure providers are serving Drug Medi-Cal eligible clients.

E. Costs for services provided by respondents selected through this RFQ process are subject to State cost reporting requirements. Respondents should be mindful of the cost reporting requirements when completing Attachment D – DMC-ODS Provider Rate Template.

3. Eligibility

To be eligible to enter into an agreement with the County as a result of this RFQ, respondents must provide the following:

A. A written statement certifying the proposer’s organization is in compliance with the Drug Medi-Cal (DMC) Minimum Quality Treatment Standards in addition to the California Code of Regulations (CCR) Title 9 and 22 regulations for all Substance Use Disorder (SUD) treatment programs funded in whole or in part using DMC funding. A copy of the Minimum Quality Drug Treatment Standards for DMC has been included as Attachment B – Minimum quality Drug Treatment Standards for DMC;

B. A written statement affirming the organization will comply with the insurance requirements set forth in Attachment A – Sample Agreement for Services;

C. A written statement indicating the organization understands they will be required to negotiate and enter into an agreement with terms and conditions substantively similar to those in Attachment “A”, and that any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California; and

D. A completed copy of Attachment C – DMC-ODS Questionnaire for Service Providers.

Written Statements must be included in the Cover Letter, as specified in Section 6. – Statement of Interest and Response Content, Subsection “A”, Cover Letter. Respondents who fail to submit any of the above items will be considered non-responsive, and ineligible to participate in the subsequent contracting process.

4. Scope of Work

For the purposes of this RFQ, respondents may select any of the four identified Primary Service Areas labeled “A” – “D” for which a contract is sought; respondents may also choose to select the Adjunct Service Area “E” to accompany any other service area(s). Respondents
may not choose to apply for only the Adjunct Service Area “E” Transitional Housing Services. Each of the Service Areas includes provisions and requirements specific to the services to be provided; respondents must be willing and able to meet these requirements prior to a proposal being submitted. Respondents are encouraged to read the complete Service Area description thoroughly, as provisions and requirements vary for each Service Area.

**The County seeks providers who can provide services in the following Primary Service Areas:**

**A. CASE MANAGEMENT AND RECOVERY SERVICES**

1) The following services must be provided:

   a. Case Management
   Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management can be face-to-face or over the telephone and shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law. The components of case management include:

   - Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management;
   - Transition to a higher or lower level of SUD care;
   - Development and periodic revision of a client plan that includes service activities;
   - Communication, coordination, referral, and related activities;
   - Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
   - Monitoring the beneficiary’s progress; and
   - Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

   b. Recovery Services
   Medically necessary recovery services may be accessed after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. Recovery services may be provided face-to-face or by telephone with the beneficiary and may be provided anywhere in the community. The components of Recovery Services are:

   - Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
   - Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
   - Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
   - Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
• Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
• Support Groups: Linkages to self-help and support, spiritual and faith-based support; and
• Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

c. Assessments
Face-to-Face: Assessments shall be face-to-face and performed by qualified staffing. If the face-to-face assessment is provided by a certified counselor, the “face-to-face” interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.

Re-Assessments: Re-assessments shall occur a minimum of every 90 days, unless there are significant changes warranting more frequent re-assessments. ASAM Level of Care data shall be entered into the client file and the ASAM Level of Care report for each assessment and re-assessment within seven (7) days of the assessment/re-assessment.

ASAM Training: Staff performing assessments shall complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.

2) Performance Standards

a. Access to Care
Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be documented within seven (7) days of the intake into the Access to Care Report and provided to County on a monthly basis and upon request.

Performance Standard:
• First face-to-face appointment shall occur within five (5) and no later than ten (10) business days of initial contact.
• Timely access data will be entered into the Access to Care Report within seven (7) days of first contact for 100% of beneficiaries.

b. Transitions Between Levels of Care
Appropriate Case managers/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in client file.
Performance Standard:
- Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.

c. Care Coordination and Linkage with Ancillary Services
The Contractor shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. The Contractor shall screen for and link clients with mental and physical health, as indicated.

Performance Standard:
- There is documentation of physical health and mental health screening in 100% of beneficiary records;
- At least 80% of beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers;
- At least 70% of beneficiary records have documentation of coordination with physical health;
- At least 80% of beneficiaries engaged for at least 30 days will have an assigned Primary Care Provider;
- At least 80% of beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers; and
- At least 70% of beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).

d. Medication Assisted Treatment
Contractors will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment for substance use disorders. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.

Performance Standard:
- At least 80% of beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders will have 42 CFR compliant releases in place to coordinate care.
- At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services.

e. Culturally Competent Services
Contractors are responsible to provide culturally competent services. Contractors must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.
Performance Standard:
• 100% of beneficiaries that speak a threshold language are provided services in their preferred language.
• At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services.

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

ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in the ASAM Level of Care report within seven (7) days of the assessment.

Performance Standards:
• Contractor will implement with fidelity at least two approved EBPs.
• 100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care.
• 100% of beneficiaries are re-assessed within 90 days of the initial assessment.

3) Outcomes
In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to:
• Engagement in the first 30 days of treatment, as applicable;
• Reduction in substance use;
• Reduction in criminal activity or violations of probation/parole and days in custody;
• Increase in employment or employment (and/or educational) skills;
• Increases in family reunification;
• Increase engagement in social supports;
• Maintenance of stable living environments and reduction in homelessness; and
• Improvement in mental and physical health status.

4) Training
Applicable staff are required to participate in the following training:
• Title 22, Drug/Medi-Cal (At least annually);
• Information Privacy and Security (At least annually);
• ASAM E-modules 1 and 2 (Prior to Conducting Assessments);
• Cultural Competency (At least annually); and
• Confidentiality Statement (Review and sign at hire and annually thereafter).
5) Authorization Process
Non-residential services shall not require prior authorization. See page 111 of 450: California Medi-Cal Demonstration.

6) Program Licensure, Certification, and Standards
Contractor shall be linked to a valid DHCS DMC certified facility. Contractor shall be a certified Alcohol and Drug Counselor (certified from a DHCS approved body) in good standing and must adhere to all requirements in the California Code of Regulations, Title 9, and Chapter 8.

7) Beneficiary Protections and Beneficiary Informing Materials

Beneficiary Informing Materials
Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory. Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Refer to 42 CFR 438.10(g) (2) (xi) for additional information about the grievance and appeal system.

Notice of Adverse Benefit Determination (NOABD)
Contractor shall have written procedures to ensure compliance with the following:

- Contractor shall request consent from beneficiaries for the County of El Dorado to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. Should a beneficiary refuse to consent, then the Contractor is responsible for issuing any applicable NOABD directly to the beneficiary.
- Contractor shall immediately notify the County in writing of any actions that may require a NOABD be issued, including, but not limited to: 1) not meeting timely access standards; 2) not meeting medical necessity for any substance use disorder treatment services; and 3) terminating or reducing authorized covered services.

8) Contract Changes
If significant changes are expected, the Contractor will be required to submit a request in writing to the contract administrator. Written approval must received prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:

Changes to Scope of Work
- Proposing to re-distribute units of service between existing service codes by more than 20%;
- Proposing to add or remove a service modality;
- Proposing to transfer substantive programmatic work to a subcontractor; and/or
- Proposing to provide any services by telephone or field-based.
Changes to Budget

- Proposing to re-distribute more than 20% between budget categories;
- Proposing to increase or decrease FTE; and/or
- Proposing to increase the contract maximum.

Contractor shall also report any other key changes per the timelines and processes outlined in applicable County Policies and Procedures including, but not limited to:
1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).

B. OUTPATIENT AND INTENSIVE OUTPATIENT

1) The following services must be provided:

a. Outpatient Services (ASAM Level 1): Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) to be medically necessary and in accordance with an individualized client plan.

b. Intensive Outpatient Treatment (IOT) (ASAM Level 2.1): Structured programming services provided to beneficiaries a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents, when determined by a Medical Director or LPHA to be medically necessary and in accordance with the individual treatment plan. Services consist primarily of counseling and education about addiction-related problems.

The components of Outpatient and IOT services include the following services:

- Intake: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders, the diagnosis of substance use disorders, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- Individual and/or Group Counseling: Contacts between a beneficiary and a therapist or counselor.
- Patient Education: Provide research based education on addiction, treatment, recovery, and associated health risks.
- Family Therapy: The effects of addiction are far-reaching and patient’s family members and loved ones are also affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient’s recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
- Medication Services: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

- Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary’s treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

- Crisis Intervention Service: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary’s emergency situation.

- Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within the regulatory timeframe then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.

- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.

c. Case Management: Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management can be face-to-face or over the telephone and shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

The components of case management include:
- Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management;
- Transition to a higher or lower level of SUD care;
- Development and periodic revision of a client plan that includes service activities;
- Communication, coordination, referral, and related activities;
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
- Monitoring the beneficiary’s progress; and
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

d. Physician Consultation: Services include DMC physicians’ consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they
are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

e. Assessments

Face-to-Face: Assessments shall be face-to-face and performed by qualified staffing. If the face-to-face assessment is provided by a certified counselor, the “face-to-face” interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.

Re-Assessments: Re-assessments shall occur a minimum of every 90 days, unless there are significant changes warranting more frequent re-assessments. ASAM Level of Care data shall be entered into the client file and the ASAM Level of Care report for each assessment and re-assessment within seven (7) days of the assessment/re-assessment.

ASAM Training: Staff performing assessments shall complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.

2) Performance Standards

a. Access to Care

Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be documented within seven (7) days of the intake into El Dorado County’s Access to Care Report template and provided to County on a monthly basis and upon request.

Performance Standard:

- First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact.
- First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within five (5) and no later than 10 business days.
- At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services.
- Timely access data will be entered into the Access to Care Report within seven (7) days of first contact for 100% of beneficiaries.

b. Transitions Between Levels of Care

Appropriate Case managers/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal
delay between discharge and admission at the next level of care, providing
transportation as needed, and documenting all information in client file.

Performance Standard:
• Transitions between levels of care shall occur within five (5) and no later than
10 business days from the time of re-assessment indicating the need for a
different level of care.

c. Care Coordination and Linkage with Ancillary Services
The Contractor shall ensure 42 CFR Part 2 compliant releases are in place in order
to coordinate care. The Contractor shall screen for and link clients with mental
and physical health, as indicated.

Performance Standard:
• There is documentation of physical health and mental health screening in
100% of beneficiary records;
• At least 80% of beneficiaries have 42 CFR compliant releases in place to
coordinate care with physical health providers;
• At least 70% of beneficiary records have documentation of coordination with
physical health;
• At least 80% of beneficiaries engaged for at least 30 days will have an
assigned Primary Care Provider;
• At least 80% of beneficiaries who screen positive for mental health disorders
have 42 CFR compliant releases in place to coordinate care with mental health
providers; and
• At least 70% of beneficiary records for individuals who screen positive for
mental health disorders have documentation of coordination with mental
health (e.g. referral for mental health assessment or consultation with existing
providers).

d. Medication Assisted Treatment
Contractors will have procedures for linkage/integration for beneficiaries
requiring medication assisted treatment for substance use disorders. Contractor
staff will regularly communicate with physicians of beneficiaries who are
prescribed these medications unless the beneficiary refuses to consent a 42 CFR,
Part 2 compliant release of information for this purpose.

Performance Standard:
• At least 80% of beneficiary records for individuals receiving Medication
Assisted Treatment for substance use disorders will have 42 CFR compliant
releases in place to coordinate care.
• At least 80% of beneficiaries with a primary opioid or alcohol use disorder
will be linked to an MAT assessment and/or MAT services.

e. Culturally Competent Services
Contractors are responsible to provide culturally competent services. Contractors
must ensure that their policies, procedures, and practices are consistent with the
principles outlined and are embedded in the organizational structure, as well as
being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

Performance Standard:
- 100% of beneficiaries that speak a threshold language are provided services in their preferred language.
- At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services.

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

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

ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in El Dorado County’s ASAM Level of Care report template within seven (7) days of the assessment.

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

3) Outcomes
In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to:
- Engagement in the first 30 days of treatment, as applicable;
- Reduction in substance use;
• Reduction in criminal activity or violations of probation/parole and days in custody;
• Increase in employment or employment (and/or educational) skills;
• Increases in family reunification;
• Increase engagement in social supports;
• Maintenance of stable living environments and reduction in homelessness;
• Improvement in mental and physical health status; and
• Beneficiary satisfaction as measured through the Treatment Perceptions Survey.

4) Training
Applicable staff are required to participate in the following training:
• Title 22, Drug/Medi-Cal (At least annually);
• Information Privacy and Security (At least annually);
• ASAM E-modules 1 and 2 (Prior to Conducting Assessments);
• Cultural Competency (At least annually); and
• Confidentiality Statement (Review and sign at hire and annually thereafter).

5) Authorization Process
Non-residential services shall not require prior authorization. See page 111 of 450: California Medi-Cal Demonstration.

6) Program Licensure, Certification, and Standards
Contractor shall possess valid DHCS Alcohol and Drug Certification and DHCS DMC certification for the contracted level of care.

7) Beneficiary Protections and Beneficiary Informing Materials
Beneficiary Informing Materials
Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory.

Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Refer to 42 CFR 438.10(g) (2) (xi) for additional information about the grievance and appeal system.

Notice of Adverse Benefit Determination (NOABD)
Contractor shall have written procedures to ensure compliance with the following:
• Contractor shall request consent from beneficiaries for the County of El Dorado to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. Should a beneficiary refuse to consent, then the Contractor is responsible for issuing any applicable NOABD directly to the beneficiary.
• Contractor shall immediately notify the County in writing of any actions that may require a NOABD be issued, including, but not limited to: 1) not meeting timely
access standards; 2) not meeting medical necessity for any substance use disorder
treatment services; and 3) terminating or reducing authorized covered services.

8) Contract Changes
If significant changes are expected, you must submit a request in writing to the
contract administrator. You must receive written approval prior to any changes being
implemented and/or reimbursed. Significant changes include, but are not limited to:

Changes to Scope of Work
• Proposing to re-distribute units of service between existing service codes by more
than 20%;
• Proposing to add or remove a service modality;
• Proposing to transfer substantive programmatic work to a subcontractor; and/or
• Proposing to provide any services by telephone or field-based.

Changes to Budget
• Proposing to re-distribute more than 20% between budget categories;
• Proposing to increase or decrease FTE; and/or
• Proposing to increase the contract maximum.

Contractor shall also report any other key changes per the timelines and processes
outlined in applicable County Policies and Procedures including, but not limited to: 1) Staff
Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility
at capacity).

C. OPIOID (NARCOTIC) TREATMENT PROGRAM

1) Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services are provided in
NTP licensed facilities. Medically necessary services are provided in accordance with
an individualized treatment plan determined by a licensed physician or licensed
prescriber and approved and authorized according to the State of California
requirements.

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

a. A patient must receive at minimum fifty minutes of counseling sessions with a
therapist or counselor for up to 200 minutes per calendar month, although
additional services may be provided based on medical necessity.

b. The components of Opioid (Narcotic) Treatment Programs are (see Outpatient
Treatment Services for definitions):
• Intake: The process of determining that a beneficiary meets the medical
necessity criteria and a beneficiary is admitted into a substance use disorder
treatment program. Intake includes the evaluation or analysis of substance use
disorders, the diagnosis of substance use disorders, and the assessment of
treatment needs to provide medically necessary services. Intake may include a
physical examination and laboratory testing necessary for substance use disorder treatment.

- Individual and/or Group Counseling: Contacts between a beneficiary and a therapist or counselor.
- Patient Education: Provide research based education on addiction, treatment, recovery, and associated health risks.
- Medication Services: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.
- Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary’s treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
- Crisis Intervention Service: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary’s emergency situation.
- Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within the regulatory timeframe then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.
- Medical Psychotherapy: Type of counseling services consisting of a face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient.
- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services

D. WITHDRAWAL MANAGEMENT AND RESIDENTIAL

1) Services to be provided include:

   a. Residential Withdrawal Management (ASAM Level 3.2-WM) – Clinically Managed Residential Withdrawal Management (WM)

   WM services are provided when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process.
The components of Withdrawal Management services include:
- **Intake**: The process of admitting a beneficiary into a substance use disorder (SUD) treatment program. Intake includes the evaluation or analysis of SUD, the diagnosis of SUD, the assessment of treatment needs, and may include a physical examination and laboratory testing necessary for SUD treatment.
- **Observation**: The process of monitoring the beneficiary’s course of withdrawal as frequently as deemed appropriate for the beneficiary. This may include, but is not limited to, observation of the beneficiary’s health status.
- **Medication Services**: The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.
- **Discharge Services**: Preparing the beneficiary for referral into another level of care, post treatment return, re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services.

b. Residential (ASAM Level 3.1) – Clinically Managed Low Intensity
Provides 24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.

c. Residential (ASAM Level 3.5) Clinically Managed High-Intensity
Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.

Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan. Room and Board is not reimbursable through the DMC program.

The components of Residential Treatment Services include:
- **Intake**: The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- **Individual and Group Counseling**: Contacts between a beneficiary and a therapist or counselor. Services are provided in-person or by telephone qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.
- **Patient Education**: Provide research-based education on addiction, treatment, recovery, and associated health risks.
- **Family Therapy**: The effects of addiction are far-reaching and patient’s family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are
important to the patient’s recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

- Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident’s self-administration of medication.
- Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary’s treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
- Crisis Intervention Services: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary’s emergency situation.
- Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within regulatory timeframes, reviewed every 30 days, and then updated every 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.
- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

d. Physician Consultation: Services include DMC physicians’ consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

e. Assessments
Face-to-Face: Assessments shall be face-to-face and performed by qualified staffing. If the face-to-face assessment is provided by a certified counselor, the “face-to-face” interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.
ASAM Training: Staff performing assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”.

Re-Assessments: Adult beneficiaries in Residential treatment shall be re-assessed at a minimum of every 45 days. Youth beneficiaries in Residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments. ASAM Level of Care data shall be entered into client file and ASAM Level of Care Report for each assessment and re-assessment and within seven (7) days of the assessment/re-assessment.

2) Performance Standards Include

   a. Access to Care
      Timeline access data – including date of initial contact, date of first offered appointment and date of scheduled assessment – shall be entered into Access to Care Report within seven (7) days of the intake.

      Performance Standard:
      • First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact.
      • First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within five (5) and no later than 10 business days.
      • At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location of services.
      • Timely access data will be entered into the Access to Care Report within seven (7) days of first contact for 100% of beneficiaries.

   b. Transition Between Levels of Care
      Appropriate Case managers/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in client file.

      Performance Standard:
      • Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.

   c. Care Coordination and Linkage with Ancillary Services
      The Contractor shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. The Contractor shall screen for and link clients with mental and physical health, as indicated.

      Performance Standard:
      • There is documentation of physical health and mental health screening in 100% of beneficiary records.
• At least 80% of beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers.
• At least 70% of beneficiary records have documentation of coordination with physical health.
• At least 80% of beneficiaries engaged for at least 30 days will have an assigned Primary Care Provider.
• At least 80% of beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers.
• At least 70% of beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).

d. Medication Assisted Treatment
Contractors will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment for substance use disorders. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.

Performance Standard:
• At least 80% of beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders will have 42 CFR compliant releases in place to coordinate care.
• At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services.

e. Culturally Competent Services
Contractors are responsible to provide culturally competent services. Contractors must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

Performance Standard:
• 100% of beneficiaries that speak a threshold language are provided services in their preferred language.
• At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services.

f. Delivery of Individualized and Quality Care
Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.
Evidence-Based Practices (EBPs): Contractors will implement—and assess fidelity to—at the least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.

ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in ASAM Level of Care report within seven (7) days of the assessment.

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

3) Client Outcomes
In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that will be evaluated and measured include, but are not limited to:
- Engagement in the first 30 days of treatment (at least two treatment sessions within 30 days after initiating treatment);
- Reduction in substance use;
- Reduction in criminal activity or violations of probation/parole and days in custody;
- Increase in employment or employment (and/or educational) skills;
- Increases in family reunification;
- Increase engagement in social supports;
- Maintenance of stable living environments and reduction in homelessness;
- Improvement in mental and physical health status; and
- Beneficiary satisfaction.

4) Training
Applicable staff are required to participate in the following training:
- Title 22, Drug/Medi-Cal (At least annually);
- Information Privacy and Security (At least annually);
- ASAM E-modules 1 and 2 (Prior to Conducting Assessments);
- Cultural Competency (At least annually); and
5) Authorization Process – ASAM Levels 3.1 and 3.5

a. Initial Authorization
Requests for initial authorization are to be submitted to El Dorado County Alcohol and Drug Programs on the Treatment Authorization Request (TAR) form at least 24 hours before the scheduled admission date. A copy of the ASAM Continuum or County-provided ASAM assessment tool shall be attached to the TAR. Initial authorizations can be granted for up to 30 days for youth and up to 45 days for adults. An approved authorization allows for a client to be admitted to treatment within seven (7) calendar days of the approval date. Admissions later than seven (7) calendar days from the authorization date will be considered on a case-by-case basis and will require written approval by the County.

b. Continuing Authorization
Requests or continuing authorizations are to be submitted to El Dorado County Alcohol and Drug Programs on the TAR-Extension Request form seven (7) calendar days before the expiration date of the current authorization. A copy of the re-assessment (ASAM Continuum or County-provided ASAM assessment tool) shall be attached to the TAR. For youth, a one-time extension for up to 30 days on an annual basis can be granted. For adults, continuing authorizations can be granted for up to an additional 45 days, for a total length of stay not to exceed 90 days. A one-time extension for up to 30 days on an annual basis can be granted, for a total length of stay not to exceed 120 days. Only two, non-continuous, 90 day regimens will be authorized in a one year period. Perinatal, EPSDT and criminal justice clients may receive a longer length of stay based on medical necessity.

c. Additional Information – TARs
For a TAR to be considered eligible for authorization, the individual must be an El Dorado County Medi-Cal beneficiary and meet medical necessity and the ASAM criteria for the proposed level of care. Payment and submission of claims to Medi-Cal are subject to a beneficiary’s eligibility and services being rendered and documented in accordance with Title 22, ASAM diagnostic and dimensional criteria and the DMC-ODS STCs.
If BHRS Access responds to a TAR as “pending”, Contractor shall respond within 24 hours of the request for additional information.

6) Program Licensure, Certification, and Standards
ASAM 3.2-WM: Contractor shall possess valid DHCS licensure with detoxification service authorization and DMC Residential certification.

ASAM Levels 3.1 and 3.5: Contractor shall possess valid DHCS licensure and DMC Residential certification and have been designated by DHCS as capable of delivering care consistent with the ASAM criteria.

Contractors that provide Women and Children’s Residential Treatment Services shall comply with the program requirements (Section 2.5, Required
Supplemental/Recovery Support Services) of the Substance Abuse and Mental Health Services Administration’s Grant Program for Residential Treatment for Pregnant and Postpartum Women, RFA found at http://www.samhsa.gov/grants/grant-announcements/ti-14-005.

7) Beneficiary Protections and Beneficiary Informing Materials

Beneficiary Informing Materials
Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory.

Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Refer to 42 C FR 438.10(g)(2)(xi) for additional information about the grievance and appeal system.

Notice of Adverse Benefit Determination (NOABD)
Contractor shall have written procedures to ensure compliance with the following:
• Contractor shall request consent from beneficiaries for the County of El Dorado to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. Should a beneficiary refuse to consent, then the Contractor is responsible for issuing any applicable NOABD directly to the beneficiary.
• Contractor shall immediately notify the County in writing of any actions that may require a NOABD be issued, including, but not limited to: 1) not meeting timely access standards; 2) not meeting medical necessity for any substance use disorder treatment services; and 3) terminating or reducing authorized covered services.

8) Contract Changes
If significant changes are expected, you must submit a request in writing to the contract administrator. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:

Changes to Scope of Work
• Proposing to re-distribute units of service between existing service codes by more than 20%;
• Proposing to add or remove a service modality;
• Proposing to transfer substantive programmatic work to a subcontractor; and/or
• Proposing to provide any services by telephone or field-based.

Changes to Budget
• Proposing to re-distribute more than 20% between budget categories;
• Proposing to increase or decrease FTE; and/or
• Proposing to increase the contract maximum.
Contractor shall also report any other key changes per the timelines and processes outlined in applicable El Dorado County Policies and Procedures including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).

Respondents may also choose to contract for the following Adjunct Service Area, in addition to the Primary Service Areas identified in “A – D” above:

E. TRANSITIONAL HOUSING

1) Transitional Housing (TH) programs are a safe, clean, sober, residential environment that promotes individual recovery through positive peer group interactions among house members and staff. Transitional Housing programs are affordable, alcohol and drug free and allow the residents to continue to their treatment and/or develop their individual recovery plans and to become self-supporting. In doing so, the Transitional Housing Program must co-exist in a respectful, lawful, non-threatening manner within residential communities in El Dorado County. The El Dorado County Health and Human Services – Alcohol and Drug Programs will provide oversight and quality assurance through monthly reporting, semi-annual site visits and audits with contractual Transitional Housing services.

Each resident will be authorized by the County for admission and length of stay. Program/house manager to meet with resident and complete necessary paperwork.

TH does not provide SUD services or require licensure by DHCS. All TH residents must be actively engaged in SUD treatment services to be provided off-site.

Standards of Operation
The Transitional Housing Program shall provide 24-hour safe housing, free from alcohol and other drugs which, at a minimum, shall include the following components:

a. Residents shall be required to attend regular house meetings with house managers, and/or operators. These meetings may be in a group setting with other residents of the Transitional Housing Program. House rules may include curfew, smoking, chores, payment of rent, and attendance at house meetings, and A.A. /N.A. meetings, and must include prohibition of any use of alcohol and or drugs.

b. Residents shall be provided with opportunities to engage in regular activities necessary (or optional) that define a residence such as cooking, laundry, housecleaning, yard work, etc.

c. Each Transitional Housing shall have a "common area" with adequate space for the proper number of residents to assemble for social and/or other group activities.

d. Each Transitional Housing shall have adequate personal space for each resident to be provided dignity, respect and appropriate privacy at all times, and the
Transitional Housing will comply with applicable guidelines for the amount of square feet per resident and the number of residents per room; Attention should be given to the health and safety of all residents and therefore the home should meet minimum fire and health standards.

e. Transitional Housing operators and house managers shall take appropriate measures to ensure that the personal property of each resident is secure.

f. The Transitional Housing shall establish and maintain a culture and environment that is welcoming and understanding to those they serve.

g. All residents shall have access to the: kitchen, refrigerator, stove, dining room, laundry facilities, restrooms, and showers to ensure basic needs are met.

h. The following minimum health safety requirements shall be followed:
   - There shall be adequate space for food storage;
   - All food shall be stored in covered containers, or properly wrapped;
   - Perishable items shall be refrigerated and adequate refrigeration in good repair shall be available;
   - All dishes and cooking implements shall be washed upon use;
   - There shall be adequate hot water for dish washing;
   - Bathroom space shall be adequate for number of residents;
   - Bathrooms shall be kept clean on a daily basis;
   - Bathrooms shall provide personal privacy; and
   - There is a policy for drug testing.

i. The Transitional Housing shall post a written description of the procedural processes regarding chores, assignment of roommates, and primary house rules in a space that is accessible to all residents.

j. The Transitional Housing shall be a non-smoking residence. If the operator’s policy is to allow smoking on the property, a smoking area must be designated clearly in an outdoor space where smoke will not affect neighbors and is in compliance with any and all local smoking rules/ordinances. (A Good Neighbor Policy should also be established between the Transitional Housing operator and direct neighbors of the Transitional Housing). Any and all litter generated in a designated smoking area must be cleaned up daily.

k. Each Transitional Housing shall afford residents opportunities to engage in daily recreational, cultural, physical, and spiritual activities, either as an individual or with a group.

l. All Transitional Housing residents MUST be engaged in employment, treatment, education, volunteer work, active job search (for a defined period), or other approved daily activities conducive to the recovery process.

m. Transitional Housing proprietors are responsible for ensuring neighborhood parking is in compliance with town/city ordinances and is NOT intrusive to neighbors.
n. Transitional Housing proprietors shall establish and maintain a "Good Neighbor Policy."

o. The following minimum fire safety requirements shall be followed:
   • There shall be no smoking in residences (including porches, patios, and balconies);
   • Smoking is allowed outside only (20 feet from any door or operable window) and smoking materials shall be disposed of safely;
   • There shall be no accumulation of clothing, newspapers, or cartons in the living/sleeping areas;
   • Stoves and cooking areas shall be kept clean of grease accumulation;
   • Furniture and drapes are treated with fire retardant materials;
   • Smoke detectors fire extinguishers, and CO2 detectors shall be installed (according to El Dorado County Fire Code);
   • Exit doors shall be clearly marked and readily available;
   • Fire drills from sleeping areas should be encouraged; and
   • Buildings with 2nd floor shall have emergency fire ladders clearly marked.

House Rules
Transitional Housing rules must be clearly defined. Any optional rules the Transitional Housing proprietor chooses to implement must be for the needs of the residents, shall not be overly burdensome, and must be consistent across multiple residents. The following should be considered minimum mandatory standards for every Transitional Housing:

a. There shall be no consuming alcohol and/or other drugs by anyone on the property of the Transitional Housing.

b. Alcohol and items containing alcohol shall not be brought onto the property for any reason.

c. Alcohol and other drug use may be grounds for dismissal from the Transitional Housing program. Upon being notified of possible alcohol and/or other drug use by a resident, the House Manager shall refer the resident to El Dorado County for assessment for withdrawal management services.

d. Regular attendance of house meetings shall be mandatory for all residents and it shall be the responsibility of Transitional Housing management to ensure proper participation.

e. Operators or House Managers in charge of an individual Transitional Housing facility must be accessible to residents daily. The operator and/or House Manager shall be clearly and easily identified and shall remain available at all times.

f. Each Transitional Housing shall have in its house rulebook a policy addressing visitation including hours, terms of contact, areas for visitation, visitor access, child visitation and monitoring, etc.
Required Policies
a. Confidentiality
b. Sexual Harassment & Verbal Abuse
c. Weapons, Alcohol, Illegal Drugs and Illegal Activity
d. Prescribed Medication Policy
e. Drug and Alcohol Testing Protocol
f. Management and Staff Responsibilities
g. Documentation/Record Keeping/Financial Agreements
h. Incident Report Policy

2) Performance Standards
All residents must have a personal file that contains at a minimum the following items:
• Basic personal information such as name, DOB, emergency contact, etc.
• Recognition of client rights, house expectations, grievance and complaint procedures.
• Initial financial assessment done at entry and every month thereafter. Note: County is to be notified when residents’ financial status changes affects resident share of cost.
• Appropriate releases of information, as they apply.
• Current employment status, updated as needed, and proof of salary (i.e. a copy of check stub).
• Urinalysis results.
• Any incident reports regarding resident.
• Documentation of referrals to County for withdrawal management services assessment.

3) Authorization Process
For a TAR to be considered eligible for authorization, the individual must be an El Dorado County Medi-Cal beneficiary and meet medical necessity and the ASAM criteria for the proposed level of care, this service will be provided based on funding availability.

4) Program Licensure, Certification, and Standards
Contractor shall comply with any and all federal, state and local laws as a residential member of El Dorado County.
Contractor shall agree to comply with El Dorado County Guidelines for Transitional Housing Programs.

5) Contract Changes
If significant changes are expected, you must submit a request in writing to the contract manager. Changes include significant program or policy revisions, or proposing to redistribute more than 20% between budget categories, proposing to increase or decrease FTE or proposing to increase the contract maximum.

Contractor shall also report any other key changes per the timelines and processes outlined in applicable El Dorado County Policies and Procedures including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual
occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).

5. **Provider Selection Appeals Process**

If an eligible organization has submitted a proposal for services identified in this RFQ and is denied an opportunity to negotiate a contract, the organization may appeal the denial if the organization believes it was not selected due to an error on the part of the County. For the purposes of this RFQ, the appeal process includes an initial appeal to the County of El Dorado, Health and Human Services Agency, utilizing the County Level Appeal process, followed by (if necessary) an appeal to the State of California, Department of Health Care Services, utilizing the State Level Appeal Process.

A. **County Level Appeal Process – County of El Dorado, Health and Human Services Agency**

1) **Award Denial:** If the County has rejected a proposal submitted in response to this RFQ process, the County will issue a written notice (herein referred to as an Award Denial), addressed to the organization identified in the proposal, by way certified U.S. mail, indicating the proposal to contract for DMC-ODS Waiver services has been denied. Written notice will be generated within (30) calendar days of the close of the RFQ, and will detail the qualification standard the proposer failed to meet.

2) **Right to Appeal:** If the proposer believes the County rejected its proposal erroneously, the proposer may appeal to the County in writing, within ten (10) calendar days of receiving written notice of the Award Denial.

3) **Appeal Procedure:** The organization’s written appeal to the County should include, at a minimum, the following:
   - The name and contact information of a representative within the organization whose proposal was rejected;
   - A description of the error the County made in assessing the qualifications of the organization. This description should clearly reference the documentation submitted by the organization in response to this RFQ that substantiates the required qualifications as identified in the RFQ or otherwise identified in regulation.

Appeals should be made to the attention of the Director of the Health and Human Services Agency, mailed using certified U.S. Mail, and addressed as follows:

   County of El Dorado
   Health and Human Services Agency
   3057 Briw Rd, Suite A
   Placerville, CA 95667
   Attn: Patricia Charles-Heathers, M.P.A, Ph.D., Director
   RE: DMC-ODS Waiver - Award Rejection Appeal

4) **Appeal Decision:** Upon receipt of an appeal, the Director of the Health and Human Services Agency will, within 30 calendar days, issue an Appeal Decision, either
approving the appeal or rejecting the appeal. If the appeal is approved, the organization may then begin the contracting process for DMC-ODS Waiver services, as identified in their proposal. If the Director rejects the appeal, the County Level Appeal Process is complete; the organization may choose to appeal the decision through the State Level Appeal Process.

5) Limitation of the Appeal Process: The County Level Appeal Process has been established to determine whether or not errors were made in determining if a proposing organization is qualified, and as a result, may enter into negotiations with the County for services identified in this RFQ. Failure to receive a contract with the County because of unsuccessful negotiations is not grounds for an appeal through this Appeal Process.

B. State Level Appeal Process – State of California, Department of Health Care Services
The California Department of Health Care Services has established a formal appeals process whereby providers may contest a county’s decision to deny contracting for DMC-ODS Waiver Service. The Centers for Medicare and Medicaid Services has outlined guidelines for this appeal process in the Special Terms and Conditions of California’s Medi-Cal 2020 Section 1115(a) Medicaid Demonstration, Attachment “Y”. The provider appeal process gives providers the opportunity to appeal erroneous rejections from the county they have attempted to contract with to ensure counties are adhering to their provider selection criteria, as required in State and County Intergovernmental Agreements and Title 42, Code of Federal Regulations, Section 438.214.

If a provider determines its proposal for DMC-ODS Waiver services is erroneously rejected by a county, the provider has the right to appeal the decision through an appeal procedure established by the county. If the county level appeal is unsuccessful, the provider may elevate its appeal to DHCS, if the provider:
- Meets all objective qualification criteria needed to provide services;
- Has reason to believe the county has an inadequate network of providers to meet beneficiary needs; and
- Can demonstrate it is capable of high quality services under the current, DHCS approved, county rates for service.

To initiate the CDHCS appeal process, the provider must notify the county of its intent to appeal to DHCS via certified mail, facsimile, or personal delivery within 30 calendar days from the date of the county’s appeal decision. The notice must be accompanied by a Proof of Service.

The Provider is required to notify CDHCS of its intent to appeal the county’s decision by submitting the DMC-ODS Waiver Provider Selection Appeal Form (Appeal Form) within 30 calendar days from the date of the county’s appeal decision. The Appeal Form can be found at: [http://www.dhcs.ca.gov/provgovpart/Pages/County_Resources.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/County_Resources.aspx) and submitted along with the required supporting documents to ODSSubmissions@dhcs.ca.gov.

The required supporting documents are listed on the Appeal Form and include the following:
- Proof of Services to the County;
• County’s solicitation document;
• Provider’s response to the county’s solicitation document;
• County’s written decision not to contract;
• Documentation submitted for the purposes of the county level appeal;
• Decision from the county level appeal; and
• Evidence supporting the basis of the DHCS appeal.

After being notified of a provider’s intent to appeal to CDHCS, the County will, within ten working days from the date set forth on the provider’s Proof of Service, submit a written response with supporting documents to CDHCS via email, with a copy of said documentation sent to the provider within the same time period.

Upon receiving the county’s response to the provider’s appeal, DHCS has ten calendar days to schedule an appeal meeting. This meeting will be facilitated by DHCS. If it is determined the county has erroneously rejected a provider’s proposal, the county is required to submit a Corrective Action Plan (CAP) to address the deficiency. The CAP is required to detail how the county will follow its solicitation procedure to remedy the issue(s) identified by DHCS and include the date this will be achieved. If the DHCS approved CAP is not promptly implemented, DHCS may terminate the county’s DMC-ODS Waiver contract and the county will revert to providing State Plan services. The decision issued by DHCS is final and cannot be appealed. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws. If the provider believes the county violated laws or terms outside the scope of the provider appeal process, it may file a claim with the appropriate department.

6. Statement of Interest and Response Content

The Organization’s response to this RFQ shall be submitted with all necessary information and documentation needed to demonstrate the Organization’s ability to provide any of the services described herein, in addition to the following:

A. Cover Letter
The Cover Letter shall include all written statements as indicated in Section 3. Eligibility. Failure to submit any written statement, as indicated in said section, will result in the proposal being deemed unresponsive and removed from the RFQ selection process. The Cover Letter should also include a statement clearly identifying the intent of the organization of contract with the County services identified in this RFQ process; the letter must be signed by the individual authorized to enter into and execute agreements on behalf of the organization.

B. Attachment C – DMC – ODS Questionnaire for Service Providers
Failure to submit a completed questionnaire will result in the proposal being deemed unresponsive and removed from the RFQ selection process. Each blank of the questionnaire should be filled out completely and to the proposer’s best ability.

C. Supporting Documentation
In order to validate eligibility for a contract as a result of this RFQ Process, respondents should submit supporting documentation that validates the organizational information
provided. This documentation will not be evaluated; it will only be used to validate proposer’s responses to questions answered in Attachment “C” or as otherwise indicated in the proposal. Supporting documents include:

- A copy of DMC License and/or DMC Certification or a copy of the Medical Director’s application to DHCS.
- A blank copy (example) of a Client Intake Paperwork package or packet.
- A blank copy (example) Client Assessment Tools.
- A blank template of a Treatment Plan.
- A Certificate of Completion of ASAM Criteria 3rd Edition Training – ASAM E-Modules 1 and 2 for staff who will be conducting assessments.
- A List of the Curriculum used in the program.
- Copies of program and service related policy and procedures related to:
  o Medi-Cal eligibility verification processes occurring on a monthly basis
  o Linking uninsured clients to resources for obtaining health insurance
  o Screening for referral for MAT assessment
  o Screening for Mental Health and Physical Health providers
  o Coordinating care with identified Mental Health/Primary Care providers
  o Tracking and maintaining outcome measures
  o Use of volunteers and/or interns
- An Organization Chart.
- Job Descriptions with duty statements, position responsibilities, and minimum qualifications for positions providing services.
- A written Code of Conduct for employees and volunteers.
- Roles and Responsibilities and Code of Conduct for the Medical Director.
- A Corporate Resolution from the governing body indicating who is authorized to conduct business and execute agreements on behalf of the organization.
- Proof of Insurance meeting the requirements and specifications as set forth in Attachment “A”.
- A copy of a negotiated Indirect Cost Rate Agreement, approved by a cognizant federal entity (if applicable).

Failure to submit any of the above referenced Supporting Documentation will not be considered unresponsive or a reason for an immediate disqualification from the RFQ selection process. However, organizations failing to submit any supporting documentation deemed necessary by County staff may be required to submit additional documentation prior to being selected to begin the contracting process.

D. Cost for Services
   The cost for services proposed should be formatted consistent with Attachment D – DMC-ODS Provider Rate Template. Respondents should utilize the “Outpatient” template for outpatient services and the “Residential” template for residential services. Costs proposed in a format inconsistent with Attachment “D” will require remediation before a contract can be negotiated.

E. Checklist
   For the convenience of respondents, a checklist of all required documents has been included as Attachment E – DMC-ODS RFQ Checklist. Please utilize this tool in order to ensure all necessary documents have been submitted with your response.
7. Response Formatting

Responses to this RFQ should adhere to the following formatting requirements:

- Response should be type written using Arial typeface and a font size of 11 points
- Type may be no more than six lines per inch
- Use standard letter size (8 ½ x 11), white paper
- Responses must be sequentially numbered throughout and bound with a binder clip in the upper left hand corner.

8. Respondent’s Questions

Questions regarding this RFQ must be submitted in writing to the Procurement and Contracts Office and must be received no later than 5:00 p.m. – on July 26, 2018. All envelopes or containers must be clearly labeled "RFQ #19-918-004, QUESTION" for convenience purposes. Envelopes or containers not clearly labeled may be overlooked and not responded to. Questions will not be accepted by telephone, facsimile (fax), electronically, or orally. The County reserves the right to decline a response to any question if, in the County’s assessment, the information cannot be obtained and shared with all potential organizations in a timely manner. A summary of the questions submitted, including responses deemed relevant and appropriate by the County, will be posted on the Procurement and Contracts website on or about August 8, 2018. All inquiries shall be submitted by U.S. mail to:

County of El Dorado
Procurement and Contracts
330 Fair Lane
Placerville, California  95667
RFQ #19-918-004 – Question

Respondents are cautioned that they are not to rely upon any oral statements that they may have obtained. Respondents shall direct all inquiries to the County Purchasing Agent and shall not contact the requesting department directly regarding any matter related to this Request for Proposal.

9. Respondent’s Submittal

Firms shall submit one (1) original and three (3) copies of their Statement of Interest and Qualifications, along with any addenda, in a sealed envelope, clearly marked on the front “RFQ 19-918-004 – DO NOT OPEN” to:

County of El Dorado
Procurement and Contracts
330 Fair Lane
Placerville, California  95667
Statements must be received in the Procurement and Contracts Division (Purchasing) office no later than 3:00 p.m., September 6, 2018. For additional information regarding this request, please contact Linda Silacci-Smith, Sr. Department Analyst at (530) 621-5417.

A respondent may withdraw its Statement of Interest and Qualifications at any time prior to the opening deadline date and time by submitting a written request for its withdrawal to the County Purchasing Agent, signed by an authorized agent of the firm. Respondents may thereafter submit a new or modified Statement of Interest and Qualifications prior to the opening deadline date and time. Modifications offered in any manner, oral or written, will not be considered. Respondents submitting less than the required number of copies may be rejected and considered “non-responsive.” Responses received beyond the deadline will not be considered, and will be returned unopened.

Notice to Respondents

The Procurement and Contracts Division no longer mails out hard copy letters advising participating Respondents of RFQ results. Please visit our website at:

http://edcaps.edcgov.us/contracts/bidresults.asp for RFQ results

RFQ results will be posted within approximately fourteen business days after the RFQ opening deadline date. The timeline for posting RFQ results may vary depending on the nature and complexity of the RFQ and the number of responses received.

10. Selection Process

The County will analyze all pertinent information submitted and will select all qualified respondents from those organizations submitting proposals. Selection by the County indicates the organization has been deemed qualified to contract for services; it does not bind the County to contract with the organization in the event mutually agreeable terms for service cannot be reached. That being said, this RFQ process is non-competitive; all organizations meeting the qualification and eligibility requirements of this RFQ will be selected to enter into negotiations for an agreement for services with the County.

Because this process is not competitive, a detailed cost proposal is not being requested. However, DMC-ODS Waiver requirements necessitate a standardized format for billing purposes, as agreed upon, contracted rates are still subject to review and approval by the State. For formatting requirements, please refer to Section 5. Statement of Interest and Proposal Content, D. Cost for Services.

Final project costs will be limited by budget constraints and funding availability for all services identified in this RFQ.
11. County’s Rights

The County reserves the right to:

1. Request clarification of any submitted information
2. Waive any informalities or irregularities in any qualification statement
3. Not enter into any agreement
4. Not select any organizations
5. Cancel this process at any time
6. Amend this process at any time
7. To award more than one contract if it is in the best interest of the County
8. Interview respondents prior to award
9. To request additional information during an interview

11. El Dorado County Website Requirements

Respondents downloading Bids, RFP’s, or RFQ’s from the County’s web site are responsible for checking the Internet up to the bid due date for any Addenda issued. Printed copies of Bids, RFP’s, RFQ’s and Addenda are only mailed out to bidders on the County’s Master Bidders list. Addenda issued may be required to be acknowledged and returned by participating firms in order to be considered further in the evaluation process. Those respondents not acknowledging and returning Addenda may not be considered and may be rejected as “non-responsive.”

12. Additional Requirements

1. Organizations submitting less than the required number of copies may be considered “non-responsive.”
2. Submittals received beyond the deadline date and time will not be considered and will be returned unopened.
3. Telephone or facsimile submittals will not be accepted.
4. Any cost incurred by the respondents in the preparation of any information or material submitted in response to the RFQ shall be borne solely by the respondent.
5. The County reserves the right to reject any and/or all submittals, or to withhold the award for any reason it may determine, and to waive or decline to waive irregularities in any submittals.
6. The County assumes no obligation in the solicitation of this general statement of interest and qualifications and all costs responding to this solicitation shall be borne by the interested firms.
7. Responses will be opened in public.
8. This RFQ does not constitute a contract nor an offer of employment. All responses, whether accepted or rejected, shall become the property of the County.
THIS AGREEMENT made and entered by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and __________________, a ________________, duly qualified to conduct business in the State of California, whose principal place of business is ____________________________________, and whose Agent for Service of Process is Company name, physical address, (hereinafter referred to as "Contractor");

RECITALS

WHEREAS, County has determined that it is necessary to obtain a Contractor to provide ____________________; and

WHEREAS, Contractor has represented to County that it is specially trained, experienced, expert and competent to perform the special services required hereunder and County has determined to rely upon such representations; and

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable federal, state and local laws; and

WHEREAS, County has determined that the provision of these services provided by Contractor is in the public's best interest, and that these services are more economically and feasibly performed by outside independent Contractors as well as authorized by El Dorado County Charter, Section 210 (b) (6) and/or Government Code 31000;

NOW, THEREFORE, County and Contractor mutually agree as follows:

ARTICLE I

Scope of Services:
A. Non-Drug Medi-Cal Services:
   1. Revenue Collection: Contractor shall set and collect client fees based on the client’s ability to pay for all services other than Prevention and Early Intervention Services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.
2. Other services to be negotiated.

ARTICLE II
Term: This Agreement shall become effective upon final execution by both parties hereto and shall expire ________________.

ARTICLE III
Compensation for Services: For services provided herein, including any deliverables that may be identified herein, County agrees to pay Contractor upon the satisfactory completion and County’s acceptance of work, monthly in arrears and within forty-five (45) days following the County’s receipt and approval of itemized invoice(s) identifying services rendered.

For the purposes of this Agreement, the billing rate shall be ____________________________________.

Total amount of this Agreement shall not exceed ________________.

Itemized invoices shall follow the format specified by County and shall reference this Agreement number on their faces and on any enclosures or backup documentation. Copies of documentation attached to invoices shall reflect Contractor’s charges for the specific services billed on those invoices. Invoices shall be mailed to County at the following address:

    County of El Dorado
    Department
    Address
    Placerville, California 95667

or to such other location as County directs.

In the event that Contractor fails to deliver the documents or other deliverables required by the individual Work Orders issued pursuant to this Agreement, County at its sole option may delay the monthly payment for the period of time of the delay, cease all payments until such time as the deliverables are received, or proceed as set forth herein below in Article ______, Default, Termination, and Cancellation.

ARTICLE IV
Reporting:
B. Narcotic Treatment Programs (NTP): In accordance with Welfare and Institutions Code 14124.24(h), certified opioid/narcotic treatment program providers that are exclusively billing the state or the county for services rendered to persons subject to Section 1210.1 or 3063.1 of the Penal Code or Section 14021.52 of this code shall submit accurate and complete performance reports for the previous state fiscal year by November 1 following the end of that fiscal year. A provider to which this subdivision applies shall estimate its budgets using the
uniform state daily reimbursement rate. The format and content of the performance reports shall be mutually agreed to by the department, the County Behavioral Health Directors Association of California, and representatives of the treatment providers.

C. **Non-Narcotic Treatment Program Providers – Cost Reporting:** Contractor shall submit a Cost Report to HHSA on or before September 15 for each year of this Agreement, covering all expenditures for services provided herein, as well as all types and amounts of revenues collected. Contractor shall prepare the Cost Report in accordance with all federal, state, and county requirements and generally accepted accounting principles. Contractor shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. Such costs and allocations shall be supported by source documentation maintained by Contractor and available at any time to County upon reasonable notice.

D. Contractor shall document that costs are reasonable and allowable, and directly or indirectly related to the services provided hereunder. The Cost Report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.

E. Final Settlement shall be based upon the actual and reimbursable costs for services hereunder. Contractor shall not claim expenditures to County that are not reimbursable pursuant to applicable federal, state, and county laws, regulations and requirements. Any payment made by County to Contractor, which is subsequently determined to have been for a non-reimbursable expenditure or service, shall be repaid by Contractor to County in cash within forty-five (45) days of submission of the Cost Report.

F. If the Cost Report shows the actual and reimbursable cost of services provided pursuant to this Agreement is lower than the aggregate of monthly payments to Contractor, contractor shall remit the difference to County. Such reimbursement shall be made with the submission of the Cost Report.

G. When the State reconciliation of costs occurs, if the State settlement shows that the aggregate of monthly payments to Contractor for covered services provided under this agreement exceeds Contractor’s allowable cost, in accordance with Title 22 CCR, Section 51516.1, within forty-five (45) days after verification of amount owed or the completion of an Appeal Process through County, whichever comes first. In the event of a State Substance Use Agreement cost report audit and/or program audit, both Local Realignment Revenue and Federal Medicaid portions of all Contractor disallowances shall be reimbursed to County within forty-five (45) days of completion of an appeal process following receipt of a final Audit Report or the completion of an Appeal Process through County, whichever comes first.

**ARTICLE V**

**Taxes:** Contractor certifies that as of today’s date, it is not in default on any unsecured property taxes or other taxes or fees owed by Contractor to County. Contractor agrees that it shall not default on any obligations to County during the term of this Agreement.
ARTICLE VI
Changes to Agreement: This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

ARTICLE VII
Contractor to County: It is understood that the services provided under this Agreement shall be prepared in and with cooperation from County and its staff. It is further agreed that in all matters pertaining to this Agreement, Contractor shall act as Contractor only to County and shall not act as Contractor to any other individual or entity affected by this Agreement nor provide information in any manner to any party outside of this Agreement that would conflict with Contractor's responsibilities to County during term hereof.

ARTICLE VIII
Assignment and Delegation: Contractor is engaged by County for its unique qualifications and skills as well as those of its personnel. Contractor shall not subcontract, delegate or assign services to be provided, in whole or in part, to any other person or entity without prior written consent of County.

ARTICLE IX
Independent Contractor/Liability: Contractor is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by terms of this Agreement. Contractor exclusively assumes responsibility for acts of its employees, associates, and subContractors, if any are authorized herein, as they relate to services to be provided under this Agreement during the course and scope of their employment.

Contractor shall be responsible for performing the work under this Agreement in a safe, professional, skillful and workmanlike manner and shall be liable for its own negligence and negligent acts of its employees. County shall have no right of control over the manner in which work is to be done and shall, therefore, not be charged with responsibility of preventing risk to Contractor or its employees.

ARTICLE X
Fiscal Considerations: The parties to this Agreement recognize and acknowledge that County is a political subdivision of the State of California. As such, El Dorado County is subject to the provisions of Article XVI, Section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment or services not budgeted in a given fiscal year. It is further understood that in the normal course of County business, County will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.
Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products or equipment subject herein. Such notice shall become effective upon the adoption of a final budget which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated and County released from any further liability hereunder.

In addition to the above, should the Board of Supervisors during the course of a given year for financial reasons reduce, or order a reduction, in the budget for any County department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of the County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

ARTICLE XI
Audit by California State Auditor: Contractor acknowledges that if total compensation under this agreement is greater than $10,000.00, this Agreement is subject to examination and audit by the California State Auditor for a period of three (3) years, or for any longer period required by law, after final payment under this Agreement, pursuant to California Government Code §8546.7. In order to facilitate these potential examinations and audits, Contractor shall maintain, for a period of at least three (3) years, or for any longer period required by law, after final payment under the contract, all books, records and documentation necessary to demonstrate performance under the Agreement.

ARTICLE XII
Default, Termination, and Cancellation:

A. Default: Upon the occurrence of any default of the provisions of this Agreement, a party shall give written notice of said default to the party in default (notice). If the party in default does not cure the default within ten (10) days of the date of notice (time to cure), then such party shall be in default. The time to cure may be extended at the discretion of the party giving notice. Any extension of time to cure must be in writing, prepared by the party in default for signature by the party giving notice and must specify the reason(s) for the extension and the date on which the extension of time to cure expires.

Notice given under this section shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable period of time. No such notice shall be deemed a termination of this Agreement unless the party giving notice so elects in this notice, or the party giving notice so elects in a subsequent written notice after the time to cure has expired. In the event of termination for default, County reserves the right to take over and complete the work by contract or by any other means.

B. Bankruptcy: This Agreement, at the option of the County, shall be terminable in the case of bankruptcy, voluntary or involuntary, or insolvency of Contractor.
C. Ceasing Performance: County may terminate this Agreement in the event Contractor ceases to operate as a business, or otherwise becomes unable to substantially perform any term or condition of this Agreement.

D. Termination or Cancellation without Cause: County may terminate this Agreement in whole or in part upon seven (7) calendar days written notice by County without cause. If such prior termination is effected, County will pay for satisfactory services rendered prior to the effective dates as set forth in the Notice of Termination provided to Contractor, and for such other services, which County may agree to in writing as necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the contract. Upon receipt of a Notice of Termination, Contractor shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the notice directs otherwise.

ARTICLE XIII
Notice to Parties: All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested. Notices to County shall be addressed as follows:

    COUNTY OF EL DORADO
    (Department Name)
    (Address)
    (City, State, Zip)
    ATTN: (Name), (Title)

or to such other location as the County directs.

with a carbon copy to

    COUNTY OF EL DORADO
    Chief Administrative Office
    Procurement and Contracts Division
    360 Fair Lane
    Placerville, CA 95667
    ATTN: Purchasing Agent

Notices to Contractor shall be addressed as follows:

    (COMPANY NAME)
    (Address)
    (City, State, Zip)
    ATTN: (Name), (Title)

or to such other location as the Contractor directs.
ARTICLE XIV
Change of Address: In the event of a change in address for Contractor's principal place of business, Contractor's Agent for Service of Process, or Notices to Contractor, Contractor shall notify County in writing pursuant to the provisions contained in this Agreement under the Article titled “Notice to Parties”. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.

ARTICLE XV
Indemnity: The Contractor shall defend, indemnify, and hold the County harmless against and from any and all claims, suits, losses, damages and liability for damages of every name, kind and description, including attorney’s fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, County employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the Contractor's services, operations, or performance hereunder, regardless of the existence or degree of fault or negligence on the part of the County, the Contractor, subContractor(s) and employee(s) of any of these, except for the sole, or active negligence of the County, its officers and employees, or as expressly prescribed by statute. This duty of Contractor to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

ARTICLE XVI
Insurance: Contractor shall provide proof of a policy of insurance satisfactory to the County of El Dorado Risk Manager and documentation evidencing that Contractor maintains insurance that meets the following requirements:

A. Full Worker’s Compensation and Employer’s Liability Insurance covering all employees of Contractor as required by law in the State of California.

B. Commercial General Liability Insurance of not less than $1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a $2,000,000.00 aggregate limit.

C. Automobile Liability Insurance of not less than $1,000,000.00 is required in the event motor vehicles are used by the Contractor in the performance of the Agreement.

D. In the event Contractor is a licensed professional or professional consultant, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than $1,000,000.00 per occurrence.
E. Contractor shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.

F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.

G. Contractor agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Contractor agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Contractor agrees that no work or services shall be performed prior to the giving of such approval. In the event the Contractor fails to keep in effect at all times insurance coverage as herein provided, County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

H. The certificate of insurance must include the following provisions stating that:

1. The insurer will not cancel the insured’s coverage without prior written notice to County, and;

2. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.

I. The Contractor’s insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be in excess of the Contractor’s insurance and shall not contribute with it.

J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Contractor shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.

L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.
M. Contractor’s obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

N. In the event Contractor cannot provide an occurrence policy, Contractor shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.

O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of the County.

ARTICLE XVII
Interest of Public Official: No official or employee of County who exercises any functions or responsibilities in review or approval of services to be provided by Contractor under this Agreement shall participate in or attempt to influence any decision relating to this Agreement which affects personal interest or interest of any corporation, partnership, or association in which he/she is directly or indirectly interested; nor shall any such official or employee of County have any interest, direct or indirect, in this Agreement or the proceeds thereof.

ARTICLE XVIII
Interest of Contractor: Contractor covenants that Contractor presently has no personal interest or financial interest, and shall not acquire same in any manner or degree in either: 1) any other contract connected with or directly affected by the services to be performed by this Agreement; or, 2) any other entities connected with or directly affected by the services to be performed by this Agreement. Contractor further covenants that in the performance of this Agreement no person having any such interest shall be employed by Contractor.

ARTICLE XIX
Conflict of Interest: The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and Section 87100 relating to conflict of interest of public officers and employees. Contractor attests that it has no current business or financial relationship with any County employee(s) that would constitute a conflict of interest with provision of services under this contract and will not enter into any such business or financial relationship with any such employee(s) during the term of this Agreement. County represents that it is unaware of any financial or economic interest of any public officer or employee of Contractor relating to this Agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this Agreement either party may immediately terminate this Agreement by giving written notice as detailed in the Article in the Agreement titled, “Default, Termination and Cancellation”.
ARTICLE XX
Nondiscrimination:

A. County may require Contractor’s services on projects involving funding from various state and/or federal agencies, and as a consequence, Contractor shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Contractor and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex; Contractor shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Sections 7285.0 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended. Contractor and its employees and representatives shall give written notice of their obligations under this clause as required by law.

B. Where applicable, Contractor shall include these nondiscrimination and compliance provisions in any of its agreements that affect or are related to the services performed herein.

C. Contractor’s signature shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, California Code of Regulations, Section 8103.

ARTICLE XXI
California Residency (Form 590): If Contractor is a California resident, Contractors must file a State of California Form 590, certifying its California residency or, in the case of a corporation, certifying that it has a permanent place of business in California. The Contractor will be required to submit a Form 590 prior to execution of an Agreement or County shall withhold seven (7) percent of each payment made to the Contractor during term of the Agreement. This requirement applies to any agreement/contract exceeding $1,500.00.

ARTICLE XXII
Nonresident Withholding: If Contractor is not a California resident, Contractor shall provide documentation that the State of California has granted a withholding exemption or authorized reduced withholding prior to execution of this Agreement or County shall withhold seven (7%) percent of each payment made to the Contractor during term of the Agreement as required by law. This requirement applies to any agreement/contract exceeding $1,500.00. Contractor shall indemnify and hold the County harmless for any action taken by the California Franchise Tax Board.
ARTICLE XXIII
Taxpayer Identification Number (Form W-9):  All independent Contractors or corporations providing services to the County must file a Department of the Treasury Internal Revenue Service Form W-9, certifying their Taxpayer Identification Number.

ARTICLE XXIV
County Business License:  It is unlawful for any person to furnish supplies or services, or transact any kind of business in the unincorporated territory of El Dorado County without possessing a County business license unless exempt under County Code Section 5.08.070.

ARTICLE XXV
Licenses:  Contractor hereby represents and warrants that Contractor and any of its subcontractors employed under this Agreement has all the applicable licenses, permits, and certifications that are legally required for Contractor and its subcontractors to practice its profession or provide the services or work contemplated under this Agreement in the State of California. Contractor and its subcontractors shall obtain or maintain said applicable licenses, permits, or certificates in good standing throughout the term of this Agreement.

ARTICLE XXVI
Administrator:  The County Officer or employee with responsibility for administering this Agreement is (name), (title), (department), or successor.

ARTICLE XXVII
Authorized Signatures:  The parties to this Agreement represent that the undersigned individuals executing this Agreement on their respective behalf are fully authorized to do so by law or other appropriate instrument and to bind upon said parties to the obligations set forth herein.

ARTICLE XXVIII
Partial Invalidity:  If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

ARTICLE XXIX
Venue:  Any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California.
ARTICLE XXX
No Third Party Beneficiaries: Nothing in this Agreement is intended, nor will be deemed, to confer rights or remedies upon any person or legal entity not a party to this agreement.

ARTICLE XXXI
Transfer of Records: In the event that Contractor ceases operation, all physical and electronic files that are subject to audit shall be transferred to County for proper storage of physical records and electronic data. Contractor shall notify County of impending closure as soon as such closure has been determined, and provide County with a complete list of records in its possession pertaining to County Clients and operational costs under this Agreement. County shall promptly advise Contractor which records are to be transferred to the custody of the County. Contractor shall properly destroy records not transferred to custody of County, and Contractor shall provide documentation of proper destruction of all such records to County.

ARTICLE XXXII
Additional Terms and Conditions:
Contractor and any subcontractors approved in accordance with the Article titled “Assignment and Delegation” agree to comply with applicable provisions of the State of California Standard Agreement between County and the California Department of Health Care Services (hereinafter referred to as Substance Use Disorder Agreement) available at www.edcgov.us, Health and Human Services Agency Contractor Resources.

Noncompliance with the aforementioned agreement and its terms and conditions may result in termination of this Agreement by giving written notice as detailed in the Article titled, “Default, Termination, and Cancellation.”

Additional Terms and conditions include, but are not limited to the following:
H. Hatch Act: Contractor agrees to comply with the provisions of the Hatch Act (Title 5, USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
I. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Contractor agrees that information produced through these funds, and which pertains to drug and alcohol-related programs shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol-related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this agreement, Contractor agrees that it shall enforce, and shall require its subcontractors to enforce, these requirements.
J. Noncompliance with Reporting Requirements: Contractor agrees that County has the right to withhold payments until Contractor has submitted any required data and reports, as identified herein this agreement.
K. 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).
L. **Restriction of Distribution of Sterile Needles:** No Substance Abuse Prevention and Treatment (SAPT) Block Grant funds made available through this Agreement shall be used to carry out any program that includes the distribution of sterile needs or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

M. **Health Insurance Portability and Accountability Act (HIPAA) of 1996:** If any of the work performed under this Agreement is subject to the HIPAA, Contractor shall perform the work in compliance with all applicable provisions of HIPAA (Exhibit A, Attachment I to Substance Use Agreement).

N. **Nondiscrimination and Institutional Safeguards for Religious Providers:** Contractor shall establish such processes and procedures as necessary to comply with the provisions of Title 42, USC, Section 300x-65 and Title 42, CFR, Part 54 (Reference Document 1B to Substance Use Agreement).

O. **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 certified as defined in Title 9, CCR, Division 4, Chapter 8 (Document 3H to Substance Use Agreement).

P. **Cultural and Linguistic Proficiency:** To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V to Substance Use Agreement), and comply with 42 CFR 438.206(c)(2).

Q. **Tuberculosis Treatment:** Contractor shall ensure the following related to Tuberculosis (TB) – (1) Routinely make available TB services to each individual receiving treatment for SUD use and/or abuse; (2) Reduce barriers to patients’ accepting TB treatment; and (3) Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.


S. **Youth Treatment Guidelines:** Contractor shall follow the Youth Treatment Guidelines (Document 1V to Substance Use Agreement) in developing and implementing adolescent treatment programs funded under this Agreement, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

T. **Restrictions on Grantee Lobbying:** Appropriations Act Section 503 – (1) No part of any appropriation contained in this Act shall be used, other than for formal and recognized execute-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress or any State legislative body itself. (2) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any Substance Use Agreement recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.
U. **Nondiscrimination in Employment and Services:** By signing this Agreement, Contractor certifies that under the laws of the United State and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Contractor shall not unlawfully discriminate against any person.

V. **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 IX of the education amendments of 1972 (regarding education and programs and activities), if applicable.
3. 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.
4. Age Discrimination Act of 1975 (45 FR Part 90), as amended (42 USC Sections 6101-6107), which prohibits discrimination on the basis of age.
6. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination again the disabled in employment.
8. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
10. 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.
11. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
13. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

W. **State Law Regulations:**
1. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 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 10800.
4. No state of federal funds shall be used by the Contractor or its subcontractors for sectarian worship, instruction, or proselytization. No state funds shall be used by the Contractor or its subcontractors to provide direct, immediate, or substantial support to any religious activity.
5. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement, or terminate all, or any type, of funding provided hereunder.
X. Investigations and Confidentiality of Administrative Actions:
   1. Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to Welfare and Institutions Code, Section 14043.36(a). Information about a provider’s administrative sanction status is confidential until such time as the action is either completed or resolved. The DHCS may also issue a payment suspension to a provider pursuant to W&I Code, Section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The County is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.
   2. Contractor shall execute the Confidentiality Agreement, attached as Exhibit __________ and incorporated by reference herein. The Confidentiality Agreement permits DHCS to communicate with County concerning subcontracted providers that are subject to administrative sanctions.

Y. This Agreement is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments that affect the provisions, terms, or funding of the Substance Use Agreement in any manner.

Z. Subcontract Provisions: Contractor shall include all of the foregoing provisions in all of its subcontracts.

ARTICLE XXXII:
Entire Agreement: This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

Requesting Contract Administrator Concurrence:

By: ________________________________ Dated: __________________
Name
Title
Department

Requesting Department Head Concurrence:

By: ________________________________ Dated: __________________
Name
Title
Department
IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates indicated below.

-- COUNTY OF EL DORADO --

By: _______________________________  Dated: _______________________________
   Purchasing Agent
   Chief Administrative Office
   "County"

OR

-- COUNTY OF EL DORADO --

Dated: _______________________________

By: _______________________________
   Chair
   Board of Supervisors
   "County"

ATTEST:
James S. Mitrisin
Clerk of the Board of Supervisors

By: _______________________________  Dated: _______________________________
   Deputy Clerk
-- CONTRACTOR --

IF CORPORATION, LLC, ETC.
(COMpany Name, INC.)
(A [NAME OF STATE] CORPORATION)
IF SOLE PROPRIETOR, ETC., DELETE THIS TEXT

By: ____________________________ Dated: ________________
    ____________________________
    Name
    Title
    "Contractor"

By: ____________________________ Dated: ________________
    ____________________________
    Corporate Secretary
Minimum Quality Drug Treatment Standards for DMC

Compliance with the following Minimum Quality Treatment Standards is required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC. If conflict between regulations and standards occurs, the most restrictive shall apply.

A. Personnel Policies

1. Personnel files shall be maintained on all employees and volunteers/interns and shall contain 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) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
   g) Training documentation relative to substance use disorders and treatment;
   h) Current registration, certification, intern status, or licensure;
   i) Proof of continuing education required by licensing or certifying agency and program; and
   j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.

2. Job descriptions shall be developed, revised as needed, and approved by the Program's governing body. The job descriptions shall include:
   a) Position title and classification;
   b) Duties and responsibilities;
   c) Lines of supervision; and
   d) Education, training, work experience, and other qualifications for the position.

3. Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
Minimum Quality Drug Treatment Standards for DMC

a) Use of drugs and/or alcohol;
b) Prohibition of social/business relationship with beneficiary’s or their family members for personal gain;
c) Prohibition of sexual contact with beneficiary’s;
d) Conflict of interest;
e) Providing services beyond scope;
f) Discrimination against beneficiary’s or staff;
g) Verbally, physically, or sexually harassing, threatening, or abusing beneficiary’s, family members or other staff;
h) Protection beneficiary confidentiality;
i) The elements found in the code of conduct(s) for the certifying organization(s) the program’s counselors are certified under; and
j) Cooperate with complaint investigations.

4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:
a) Recruitment;
b) Screening;
c) Selection;
d) Training and orientation;
e) Duties and assignments;
f) Scope of practice;
g) Supervision;
h) Evaluation; and
i) Protection of beneficiary confidentiality.

5. Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a program representative and physician.

B. Program Management
1. Admission or Readmission

a) Each program shall include in its policies and procedures written admission and readmission criteria for determining beneficiary’s eligibility and suitability for treatment. These criteria shall include, at minimum:

   i. DSM diagnosis;

   ii. Use of alcohol/drugs of abuse;

   iii. Physical health status; and

   iv. Documentation of social and psychological problems.

b) If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

c) If a beneficiary is admitted to treatment, a consent to treatment form shall be signed by the beneficiary.

d) The medical director shall document the basis for the diagnosis in the beneficiary record.

e) All referrals made by program staff shall be documented in the beneficiary record.

f) Copies of the following documents shall be provided to the beneficiary upon admission:

   i. Beneficiary rights, share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.


h) Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:

   i. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;

   ii. Complaint process and grievance procedures;

   iii. Appeal process for involuntary discharge; and

   iv. Program rules, expectations and regulations.

h) Where drug screening by urinalysis is deemed medically appropriate the program shall:

   i. Establish procedures which protect against the falsification and/or contamination of any urine sample; and

   ii. Document urinalysis results in the beneficiary’s file.
2. Treatment

A. Assessment for all beneficiaries shall include:

   i. Drug/Alcohol use history;
   
   ii. Medical history;
   
   iii. Family history;
   
   iv. Psychiatric/psychological history;
   
   v. Social/recreational history;
   
   vi. Financial status/history;
   
   vii. Educational history;
   
   viii. Employment history;
   
   ix. Criminal history, legal status; and
   
   x. Previous SUD treatment history.

B. Treatment plans shall be developed with the beneficiary and include:

   i. A problem statement for all problems identified through the assessment whether addressed or deferred;
   
   ii. Goals to address each problem statement (unless deferred);
   
   iii. Action steps to meet the goals that include who is responsible for the action and the target date for completion;
   
   iv. Typed or legibly printed name, signature, and date of signature of primary counselor, beneficiary, and medical director; and
   
   v. All treatment plans shall be reviewed in accordance with CCR Title 22 requirements and updated to accurately reflect the beneficiary’s progress or lack of progress in treatment.

C. Progress notes shall document the beneficiary’s progress toward completion of activities and achievement of goals on the treatment plan.

D. Discharge documentation shall be in accordance with CCR Title 22 51341.

   i. A copy of the discharge plan shall be given to the beneficiary.
## Please provide the following information about your organization:

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Name of Organization:</td>
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<tr>
<td>2</td>
<td>Business Address:</td>
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<td>3</td>
<td>CA Business Entity Number:</td>
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<td>4</td>
<td>DUNS Number (if applicable):</td>
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<tr>
<td>5</td>
<td>Name of official identified on the Corporate Resolution authorized to conduct business and execute agreements on behalf of the organization:</td>
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<tr>
<td>6</td>
<td>Authorized Agent Telephone Number:</td>
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<tr>
<td>7</td>
<td>Authorized Agent’s Email Address:</td>
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<tr>
<td>8</td>
<td>Name of Medical Director, who has enrolled with DHCS under applicable state regulations and has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as the Medical Director?</td>
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## Please answer the following questions about your organization:

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<th></th>
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<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>9</td>
<td>Has the Medical Director signed a Medicaid Provider Agreement with DHCS as required by 42 CFR 431.107?</td>
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<td>10</td>
<td>Is the organization currently identified as suspended or forfeited by the California Secretary of State?</td>
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<tr>
<td>11</td>
<td>Is the organization (as of the date of submission) in default on any unsecured property taxes or other taxes or fees owed by the organization to the County?</td>
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<tr>
<td>12</td>
<td>Is the organization insured consistent with the requirements set forth in the RFQ, including but not limited to:</td>
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<td></td>
<td>• Full Worker’s Compensation and Employer’s Liability Insurance covering all employees of the organization;</td>
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<td></td>
<td>• Commercial General Liability Insurance of not less than $1,000,000 combined single limit per occurrence for bodily injury and property damage and a $2,000,000 aggregate limit;</td>
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<tr>
<td></td>
<td>• Automobile Liability Insurance of not less than $1,000,000;</td>
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<td></td>
<td>• Professional liability insurance with a limit of liability of not less than $1,000,000 per occurrence; and</td>
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<td>• A certificate of insurance consistent with these limits has been provided to the County within the RFQ submission package.</td>
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<td>13</td>
<td>Does the organization have any current business or financial relationship with any County employees that would constitute a conflict of interest with provision of services?</td>
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<td>14</td>
<td>Has the organization obtained a County business license?</td>
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<td>15</td>
<td>Has the organization previously contracted with the County for services?</td>
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<tr>
<td>16</td>
<td>Are all professional licenses under which services will be provided in good standing with the State of California?</td>
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<td>17</td>
<td>Is the organization currently, or has it been previously, under investigation for Medi-Cal fraud?</td>
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</table>
Please Indicate what type of SUD Services your Agency is interested in providing to El Dorado County. Check all that apply:

- Outpatient: ASAM Level 1
- Intensive Outpatient: ASAM Level 2.1
- Withdrawal Management: ASAM Level 3.2
- Residential Treatment: ASAM Level 3.1
- Residential Treatment: ASAM Level 3.3
- Residential Treatment: ASAM Level 3.5
- OTP (Narcotic Treatment Program)
- Recovery Services
- Case Management
- Transitional Living Environment (may only be selected along with other services)

Does your agency…

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<th>Yes</th>
<th>No</th>
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<tr>
<td>1</td>
<td>Have a Drug Medi-Cal License to perform SUD Services (only for residential or withdrawal management)?</td>
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<td>2</td>
<td>Have a Drug-Medical Certification (or has submitted an application to) the Dept. of Health Care Services?</td>
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<td>3</td>
<td>Have an implementation plan to ensure fidelity to at least two of the following Evidence-Based Practice Models: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education.</td>
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<td>4</td>
<td>Have staff that is formally trained in ASAM Criteria 3rd Edition?</td>
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<td>5</td>
<td>Have a procedure to identify whether a client is appropriate for MAT assessment?</td>
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<td>6</td>
<td>Have a process to link clients to MAT?</td>
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<td>7</td>
<td>Have a process to check and verify Medi-Cal eligibility on a monthly basis?</td>
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<td>8</td>
<td>Have a process to link uninsured clients to resources for obtaining health insurance?</td>
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<td>9</td>
<td>Have a process to provide, either directly or through linkage to an identified provider, any services for people placed on a wait list?</td>
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<td>10</td>
<td>Have screening tools to identify whether a client is appropriate for a mental health assessment?</td>
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<tr>
<td>11</td>
<td>Have screening tools to identify whether a client is appropriate for a physical health assessment?</td>
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<td>12</td>
<td>Have a question at intake asking the client if they have a mental health provider?</td>
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<tr>
<td>13</td>
<td>Have a question at intake asking the client if they have a primary care provider?</td>
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</tr>
<tr>
<td>14</td>
<td>Request releases/consents to exchange information with identified mental health/primary care providers?</td>
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<tr>
<td>15</td>
<td>Have a process for, or designated staff person responsible for, coordinating care with identified mental health/primary care providers?</td>
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<td>16</td>
<td>Have a process for, or a designated staff person responsible for, assisting the client with access to a mental health/primary care provider?</td>
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<tr>
<td>17</td>
<td>Have written procedures to identify, track, and maintain outcome measures?</td>
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<tr>
<td>18</td>
<td>Meet the Minimum Quality Treatment Standards for the services to be provided to El Dorado County residents?</td>
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## Provider Budget Certification

**Enter information in cells highlighted yellow**

### El Dorado County DMC-ODS Provider Interim Rate Template FY 2018-19

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<tbody>
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<td><strong>1</strong> Agency</td>
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<td><strong>2</strong> Site Address</td>
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<tr>
<td><strong>3</strong> NPI</td>
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<tr>
<td><strong>4</strong> Budget/Cost Report</td>
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</tr>
<tr>
<td><strong>5</strong> Prepared By</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Title</td>
<td>Contact Phone Number</td>
</tr>
</tbody>
</table>

Methodology for Rate Development (click all that apply)

- [ ] Actual Prior Year's Costs
- [ ] Prior Year's Cost Report Submission
- [ ] Board Approved Current Year's Budget
- [ ] Other (please explain):
**Enter information in cells highlighted yellow**

### Salaries, Wages and Benefits

<table>
<thead>
<tr>
<th>Direct Service Staff (list title)</th>
<th>% FTE</th>
<th>Salary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.00</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Subtotal - Non-Direct Service Staff</td>
<td></td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Other Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.00</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Subtotal - Direct Service Staff</td>
<td></td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>Percentage</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>(list percentage)</td>
<td>10%</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Total Salary and Benefits</td>
<td></td>
<td>$165</td>
<td>$165</td>
</tr>
</tbody>
</table>

### Operating Expenses

<table>
<thead>
<tr>
<th>Line item</th>
<th>Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 300,000</td>
<td>$ 300,000</td>
</tr>
</tbody>
</table>

**Total Operating Expenses**

<table>
<thead>
<tr>
<th></th>
<th>$ 300,000</th>
<th>$ 300,000</th>
</tr>
</thead>
</table>

**Indirect Costs**

<table>
<thead>
<tr>
<th>Indirect Cost Rate ** (list percentage)</th>
<th>$30,017</th>
</tr>
</thead>
</table>

**TOTAL EXPENSE**

<table>
<thead>
<tr>
<th></th>
<th>$330,182</th>
</tr>
</thead>
</table>

**Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.**
## A. SERVICES

<table>
<thead>
<tr>
<th>Estimated Number of Individuals Receiving Treatment Services Annually</th>
<th>Standard Number of Minutes per Visit</th>
<th>Average Annual Number of Visits for each Individual</th>
<th>Estimated Total Annual Visits (all Individuals)</th>
<th>Estimated Annual Minutes of Service per each Individual</th>
<th>Estimated Total Annual Minutes of Service delivered to all Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Counseling</td>
<td>45</td>
<td>60</td>
<td>12</td>
<td>538</td>
<td>720</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>2</td>
<td>60</td>
<td>14</td>
<td>28</td>
<td>840</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>1</td>
<td>15</td>
<td>20</td>
<td>20</td>
<td>300</td>
</tr>
<tr>
<td>Case Management</td>
<td>4</td>
<td>30</td>
<td>2</td>
<td>8</td>
<td>60</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Annual Totals</strong></td>
<td><strong>52</strong></td>
<td><strong>165</strong></td>
<td><strong>48</strong></td>
<td><strong>594</strong></td>
<td><strong>1,920</strong></td>
</tr>
</tbody>
</table>

### B. ESTIMATED COSTS

(From Budget Detail)

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FTE: Direct Service Staff</td>
<td>$50</td>
</tr>
<tr>
<td>Total FTE: Other Staff</td>
<td>$100</td>
</tr>
<tr>
<td>Benefits</td>
<td>$15</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>$300,000</td>
</tr>
<tr>
<td>Indirect</td>
<td>$30,017</td>
</tr>
<tr>
<td><strong>Total Estimated Costs</strong></td>
<td><strong>$330,182</strong></td>
</tr>
</tbody>
</table>

### C. RELATIVE VALUE RATE CALCULATION

<table>
<thead>
<tr>
<th>Published (or Standard Charge per minute of service)</th>
<th>Number of Services (from (1f) above)</th>
<th>Relative Value Calculation</th>
<th>Relative Value %</th>
<th>Allocated Cost Per type of Service</th>
<th>Relative Value Cost Per Minute</th>
<th>Cost Per 15 minutes Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Counseling</td>
<td>$2.00</td>
<td>32,256</td>
<td>64,512</td>
<td>91.80%</td>
<td>$303,117</td>
<td>$9.40</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>$2.50</td>
<td>1,680</td>
<td>4,200</td>
<td>5.98%</td>
<td>$19,734</td>
<td>$11.75</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>$3.00</td>
<td>300</td>
<td>900</td>
<td>1.28%</td>
<td>$4,229</td>
<td>$14.10</td>
</tr>
<tr>
<td>Case Management</td>
<td>$2.75</td>
<td>240</td>
<td>660</td>
<td>0.94%</td>
<td>$3,011</td>
<td>$12.92</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>$2.00</td>
<td>-</td>
<td>-</td>
<td>0.00%</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>n/a</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$-</td>
<td>$-</td>
<td>n/a</td>
</tr>
<tr>
<td>n/a</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$-</td>
<td>$-</td>
<td>n/a</td>
</tr>
<tr>
<td>n/a</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$-</td>
<td>$-</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>34,476</strong></td>
<td><strong>70,272</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>$330,182</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### El Dorado County DMC-ODS Provider Interim Rate Template

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agency</td>
</tr>
<tr>
<td>2</td>
<td>Site Address</td>
</tr>
<tr>
<td>3</td>
<td>NPI</td>
</tr>
<tr>
<td>4</td>
<td>Budgeting Period</td>
</tr>
<tr>
<td>5</td>
<td>Prepared By</td>
</tr>
</tbody>
</table>

**El Dorado County DMC-ODS Provider Interim Rate Template**

Enter information in cells highlighted yellow

**Methodology for Rate Development (click all that apply):**

- [ ] Actual Prior Year’s Costs
- [ ] Prior Year’s Cost Report Submission
- [ ] Board Approved Current Year’s Budget
- [ ] Other (please explain):

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Contact Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LEVEL 3.1
RESIDENTIAL TREATMENT COST

* Enter # in cells highlighted yellow

<table>
<thead>
<tr>
<th>Personnel Services</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Salary and Benefits**

<table>
<thead>
<tr>
<th>Operating Expenses (list line items)</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Operating Expenses**

<table>
<thead>
<tr>
<th>Indirect Costs **</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect Costs **</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL RESIDENTIAL EXPENSE**

<table>
<thead>
<tr>
<th>Service Units</th>
<th>Annual Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Bed Days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential Cost Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Annual Amount</td>
</tr>
</tbody>
</table>

**Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.**
# Level 3.5

## Residential Treatment Cost

*Enter # in cells highlighted yellow*

<table>
<thead>
<tr>
<th>Personnel Services</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td>ok</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>ok</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Salary and Benefits</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

Operating Expenses *(list line items)*

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

Indirect Costs **

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indirect Costs</strong></td>
<td>ok</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL RESIDENTIAL EXPENSE**

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

** Service Units **

<table>
<thead>
<tr>
<th>Annual Units</th>
</tr>
</thead>
</table>

Residential Bed Days

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>$ -</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residential Cost Per Day</strong></td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>

** Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.**
## Level 1
### Withdrawal Management Cost

*Enter # in cells highlighted yellow*

<table>
<thead>
<tr>
<th>Personnel Services</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Salary and Benefits</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

### Operating Expenses (list line items)

- Total operating expenses: $ - $ - $ -
- Indirect costs: $ - $ - $ -

### Total Residential Expense

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>-</strong></td>
<td><strong>-</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

**Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.**
**LEVEL 2**

**WITHDRAWAL MANAGEMENT COST**

* Enter # in cells highlighted yellow

<table>
<thead>
<tr>
<th>Personnel Services</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
<th>Check totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td></td>
<td></td>
<td></td>
<td>ok</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
<td>ok</td>
</tr>
</tbody>
</table>

**Total Salary and Benefits** $ - $ - $ - $ -

**Operating Expenses (list line items)**

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>ok</td>
<td>ok</td>
<td>ok</td>
</tr>
<tr>
<td>ok</td>
<td>ok</td>
<td>ok</td>
</tr>
<tr>
<td>ok</td>
<td>ok</td>
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<td>ok</td>
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<tr>
<td>ok</td>
<td>ok</td>
<td>ok</td>
</tr>
<tr>
<td>ok</td>
<td>ok</td>
<td>ok</td>
</tr>
</tbody>
</table>

**Total Operating Expenses** $ - $ - $ -

Indirect Costs **

**TOTAL RESIDENTIAL EXPENSE** $ - $ - $ -

**Service Units**

<table>
<thead>
<tr>
<th>Annual Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Bed Days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>$ -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Cost Per Day</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>

** Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.
**LEVEL 3.2
WITHDRAWAL MANAGEMENT COST**

* Enter # in cells highlighted yellow

<table>
<thead>
<tr>
<th>Personnel Services</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
<th>Check totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td>ok</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>ok</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Salary and Benefits</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>ok</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Expenses (list line items)</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indirect</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>Treatment Services Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect Costs **</td>
<td>ok</td>
<td>ok</td>
<td>ok</td>
</tr>
</tbody>
</table>

| TOTAL RESIDENTIAL EXPENSE | $ - | $ - | $ - | ok |

<table>
<thead>
<tr>
<th>Service Units</th>
<th>Annual Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Bed Days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential Cost Per Day</th>
<th>Total Annual Amount</th>
<th>Room &amp; Board Portion</th>
<th>$ -</th>
<th>#DIV/0!</th>
</tr>
</thead>
</table>

** Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.
**RECOVERY RESIDENCE**

* Enter # in cells highlighted yellow

<table>
<thead>
<tr>
<th>Personnel Services</th>
<th>Total Annual Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td></td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
</tr>
<tr>
<td><strong>Total Salary and Benefits</strong></td>
<td>$ -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Expenses (list line items)</th>
<th>Total Annual Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Operating Expenses</th>
<th>$ -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect</td>
<td></td>
</tr>
<tr>
<td>Indirect Costs **</td>
<td></td>
</tr>
<tr>
<td>TOTAL RESIDENTIAL EXPENSE</td>
<td>$ -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Units</th>
<th>Annual Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Bed Days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential Cost Per Day</th>
<th>Total Annual Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>

** Indirect cost rate cannot exceed 10% unless organization has a federally approved indirect rate. Additionally, items included in the indirect rate cannot also be line items in the budget.
Please use this checklist to ensure all information has been submitted, consistent with the requirements of the RFQ. The following items should be included in a response to the County of El Dorado’s DMC-ODS Waiver RFQ.

<table>
<thead>
<tr>
<th>Item</th>
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</thead>
<tbody>
<tr>
<td>A Cover Letter that includes the following:</td>
</tr>
<tr>
<td>- A written statement certifying the proposer’s organization is in compliance with the Drug Medi-Cal (DMC) Minimum Quality Treatment Standards in addition to the California Code of Regulations (CCR) Title 9 and the twenty-two regulations for all Substance Use Disorder (SUD) treatment programs funded in whole or in part using DMC funding.</td>
</tr>
<tr>
<td>- A written statement affirming the organization will comply with the insurance requirements set forth in Attachment “A”.</td>
</tr>
<tr>
<td>- A written statement indicating the organization understands they will be required to negotiate and enter into an agreement with terms and conditions substantively similar to those in Attachment “A”, and that any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California.</td>
</tr>
<tr>
<td>A completed copy of Attachment “C”, the DMC-ODS Questionnaire for Service Providers</td>
</tr>
<tr>
<td>A copy of DMC License and/or DMC Certification or a copy of the Medical Director’s application to DHCS.</td>
</tr>
<tr>
<td>A blank copy (example) of a Client Intake Paperwork package or packet.</td>
</tr>
<tr>
<td>A blank copy (example) Client Assessment Tools.</td>
</tr>
<tr>
<td>A blank template of a Treatment Plan</td>
</tr>
<tr>
<td>A Certificate of Completion of ASAM Criteria 3rd Edition Training – ASAM E-Modules 1 and 2 for staff who will be conducting assessments</td>
</tr>
<tr>
<td>A List of the Curriculum used in the program</td>
</tr>
<tr>
<td>Copies of program and service related policy and procedures related to:</td>
</tr>
<tr>
<td>- Medi-Cal eligibility verification processes occurring on a monthly basis</td>
</tr>
<tr>
<td>- Linking uninsured clients to resources for obtaining health insurance</td>
</tr>
<tr>
<td>- Screening for referral for MAT assessment</td>
</tr>
<tr>
<td>- Screening for Mental Health and Physical Health providers</td>
</tr>
<tr>
<td>- Coordinating care with identified Mental Health/Primary Care providers</td>
</tr>
<tr>
<td>- Tracking and maintaining outcome measures</td>
</tr>
<tr>
<td>- Use of volunteers and/or interns</td>
</tr>
<tr>
<td>An Organization Chart</td>
</tr>
<tr>
<td>Job Descriptions with duty statements, position responsibilities, and minimum qualifications for positions providing services</td>
</tr>
<tr>
<td>A written Code of Conduct for employees and volunteers</td>
</tr>
<tr>
<td>Roles and Responsibilities and Code of Conduct for the Medical Director</td>
</tr>
<tr>
<td>A Corporate Resolution from the governing body indicating who is authorized to conduct business and execute agreements on behalf of the organization</td>
</tr>
<tr>
<td>Proof of Insurance meeting the requirements and specifications as set forth in Attachment A</td>
</tr>
<tr>
<td>A copy of a negotiated Indirect Cost Rate Agreement, approved by a cognizant federal entity (if applicable)</td>
</tr>
<tr>
<td>Attachment “D” – DMC-ODS Provider Rate Template (Outpatient, Residential, or both as applicable)</td>
</tr>
</tbody>
</table>