

Attachment A – Casa Pacifica FY 2026- 2028 Agreement for Services

Board Contract # _____

**AGREEMENT FOR SERVICES OF
INDEPENDENT CONTRACTOR
BETWEEN
COUNTY OF SANTA BARBARA
AND
CASA PACIFICA CENTERS FOR
CHILDREN AND FAMILIES
FOR
MENTAL HEALTH SERVICES**

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STANDARD TERMS AND CONDITIONS

**AGREEMENT
FOR SERVICES OF INDEPENDENT CONTRACTOR**

THIS AGREEMENT (hereafter Agreement) is made by and between the County of Santa Barbara, a political subdivision of the State of California (hereafter COUNTY) and Casa Pacifica Centers for Children and Families with an address at 1722 S. Lewis Road, Camarillo, CA 93012 (hereafter CONTRACTOR) wherein CONTRACTOR agrees to provide and COUNTY agrees to accept the services specified herein.

WHEREAS, CONTRACTOR represents that it is specially trained, skilled, experienced, and competent to perform the special services required by COUNTY and COUNTY desires to retain the services of CONTRACTOR pursuant to the terms, covenants, and conditions herein set forth;

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, the parties agree as follows:

1. DESIGNATED REPRESENTATIVE.

Director at phone number 805-681-5220 is the representative of COUNTY and will administer this Agreement for and on behalf of COUNTY. Shawna Morris at phone number 805-366-4000 is the authorized representative for CONTRACTOR. Changes in designated representatives shall be made only after advance written notice to the other party.

2. NOTICES.

Any notice or consent required or permitted to be given under this Agreement shall be given to the respective parties in writing, by personal delivery or facsimile, or with postage prepaid by first class mail, registered or certified mail, or express courier service, as follows:

To COUNTY:

Director
COUNTY of Santa Barbara
Department of Behavioral Wellness
300 N. San Antonio Road
Santa Barbara, CA 93110
Fax: 805-681-5262

To CONTRACTOR:

Shawna Moris, CEO
Casa Pacifica Center for Children and Families
1722 S. Lewis Rd.
Camarillo, CA 93012

Fax: 805-987-7237

or at such other address or to such other person that the parties may from time to time designate in accordance with this Notices section. If sent by first class mail, notices and consents under this section shall be deemed to be received five days following their deposit in the U.S. mail. This Notices section shall not be construed as meaning that either party agrees to service of process except as required by applicable law.

3. SCOPE OF SERVICES.

CONTRACTOR agrees to provide services to COUNTY in accordance with EXHIBITS A(s) and AA(s) attached hereto and incorporated herein by reference.

4. TERM.

CONTRACTOR shall commence performance on 07/01/2026 and end performance upon completion, but no later than 06/30/2027 unless otherwise directed by COUNTY or unless earlier terminated.

5. COMPENSATION OF CONTRACTOR.

In full consideration for CONTRACTOR's services, CONTRACTOR shall be paid for performance under this Agreement in accordance with the terms of EXHIBIT B(s) attached hereto and incorporated herein by reference.

6. INDEPENDENT CONTRACTOR.

It is mutually understood and agreed that CONTRACTOR (including any and all of its officers, agents, and employees), shall perform all of its services under this Agreement as an independent contractor as to COUNTY and not as an officer, agent, servant, employee, joint venturer, partner, or associate of COUNTY. Furthermore, COUNTY shall have no right to control, supervise, or direct the manner or method by which CONTRACTOR shall perform its work and function. However, COUNTY shall retain the right to administer this Agreement so as to verify that CONTRACTOR is performing its obligations in accordance with the terms and conditions hereof. CONTRACTOR understands and acknowledges that it shall not be entitled to any of the benefits of a COUNTY employee, including but not limited to vacation, sick leave, administrative leave, health insurance, disability insurance, retirement, unemployment insurance, workers' compensation and protection of tenure. CONTRACTOR shall be solely liable and responsible for providing to, or on behalf of, its employees all legally-required employee benefits. In addition, CONTRACTOR shall be solely responsible and save COUNTY harmless from all matters relating to payment of CONTRACTOR's employees, including compliance with Social Security withholding and all other regulations governing such matters. It is acknowledged that during the term of this Agreement,

CONTRACTOR may be providing services to others unrelated to the COUNTY or to this Agreement.

7. STANDARD OF PERFORMANCE.

CONTRACTOR represents that it has the skills, expertise, and licenses/permits necessary to perform the services required under this Agreement. Accordingly, CONTRACTOR shall perform all such services in the manner and according to the standards observed by a competent practitioner of the same profession in which CONTRACTOR is engaged. All products of whatsoever nature, which CONTRACTOR delivers to COUNTY pursuant to this Agreement, shall be prepared in a first class and workmanlike manner and shall conform to the standards of quality normally observed by a person practicing in CONTRACTOR's profession. CONTRACTOR shall correct or revise any errors or omissions, at COUNTY's request without additional compensation. Permits and/or licenses shall be obtained and maintained by CONTRACTOR without additional compensation.

8. DEBARMENT AND SUSPENSION.

CONTRACTOR certifies to COUNTY that it and its employees and principals are not debarred, suspended, or otherwise excluded from or ineligible for, participation in federal, state, or county government contracts. CONTRACTOR certifies that it shall not contract with a subcontractor that is so debarred or suspended. CONTRACTOR shall also comply with the debarment and suspension provisions set forth in EXHIBIT AA General Provisions ADP/MHS to this Agreement.

9. TAXES.

CONTRACTOR shall pay all taxes, levies, duties, and assessments of every nature due in connection with any work under this Agreement and shall make any and all payroll deductions required by law. COUNTY shall not be responsible for paying any taxes on CONTRACTOR's behalf, and should COUNTY be required to do so by state, federal, or local taxing agencies, CONTRACTOR agrees to promptly reimburse COUNTY for the full value of such paid taxes plus interest and penalty, if any. These taxes shall include, but not be limited to, the following: FICA (Social Security), unemployment insurance contributions, income tax, disability insurance, and workers' compensation insurance.

10. CONFLICT OF INTEREST.

CONTRACTOR covenants that CONTRACTOR presently has no employment or interest and shall not acquire any employment or interest, direct or indirect, including any interest in any business, property, or source of income, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. CONTRACTOR further covenants that in the performance of this Agreement, no person having any such

interest shall be employed by CONTRACTOR. CONTRACTOR must promptly disclose to COUNTY, in writing, any potential conflict of interest. COUNTY retains the right to waive a conflict of interest disclosed by CONTRACTOR if COUNTY determines it to be immaterial, and such waiver is only effective if provided by COUNTY to CONTRACTOR in writing. CONTRACTOR shall also comply with the conflict of interest provisions set forth in EXHIBIT AA General Provisions: ADP/MHS to this Agreement.

11. OWNERSHIP OF DOCUMENTS AND INTELLECTUAL PROPERTY.

COUNTY shall be the owner of the following items incidental to this Agreement upon production, whether or not completed: all data collected, all documents of any type whatsoever, all photos, designs, sound or audiovisual recordings, software code, inventions, technologies, and other materials, and any material necessary for the practical use of such items, from the time of collection and/or production whether or not performance under this Agreement is completed or terminated prior to completion. CONTRACTOR shall not release any of such items to other parties except after prior written approval of COUNTY.

Unless otherwise specified in Exhibit A(s), CONTRACTOR hereby assigns to COUNTY all copyright, patent, and other intellectual property and proprietary rights to all data, documents, reports, photos, designs, sound or audiovisual recordings, software code, inventions, technologies, and other materials prepared or provided by CONTRACTOR pursuant to this Agreement (collectively referred to as "Copyrightable Works and Inventions"). COUNTY shall have the unrestricted authority to copy, adapt, perform, display, publish, disclose, distribute, create derivative works from, and otherwise use in whole or in part, any Copyrightable Works and Inventions. CONTRACTOR agrees to take such actions and execute and deliver such documents as may be needed to validate, protect and confirm the rights and assignments provided hereunder. CONTRACTOR warrants that any Copyrightable Works and Inventions and other items provided under this Agreement will not infringe upon any intellectual property or proprietary rights of any third party. CONTRACTOR at its own expense shall defend, indemnify, and hold harmless COUNTY against any claim that any Copyrightable Works or Inventions or other items provided by CONTRACTOR hereunder infringe upon intellectual or other proprietary rights of a third party, and CONTRACTOR shall pay any damages, costs, settlement amounts, and fees (including attorneys' fees) that may be incurred by COUNTY in connection with any such claims. This Ownership of Documents and Intellectual Property provision shall survive expiration or termination of this Agreement.

12. NO PUBLICITY OR ENDORSEMENT.

CONTRACTOR shall not use COUNTY's name or logo or any variation of such name or logo in any publicity, advertising or promotional materials. CONTRACTOR shall not use COUNTY's

name or logo in any manner that would give the appearance that the COUNTY is endorsing CONTRACTOR. CONTRACTOR shall not in any way contract on behalf of or in the name of COUNTY. CONTRACTOR shall not release any informational pamphlets, notices, press releases, research reports, or similar public notices concerning the COUNTY or its projects, without obtaining the prior written approval of COUNTY.

13. COUNTY PROPERTY AND INFORMATION.

All of COUNTY's property, documents, and information provided for CONTRACTOR's use in connection with the services shall remain COUNTY's property, and CONTRACTOR shall return any such items whenever requested by COUNTY and whenever required according to the Termination section of this Agreement. CONTRACTOR may use such items only in connection with providing the services. CONTRACTOR shall not disseminate any COUNTY property, documents, or information without COUNTY's prior written consent.

14. RECORDS, AUDIT, AND REVIEW.

CONTRACTOR shall keep such business records pursuant to this Agreement as would be kept by a reasonably prudent practitioner of CONTRACTOR's profession and shall maintain such records for at least four (4) years following the termination of this Agreement. All accounting records shall be kept in accordance with generally accepted accounting principles. COUNTY shall have the right to audit and review all such documents and records at any time during CONTRACTOR 's regular business hours or upon reasonable notice. In addition, if this Agreement exceeds ten thousand dollars (\$10,000.00), CONTRACTOR shall be subject to the examination and audit of the California State Auditor, at the request of the COUNTY or as part of any audit of the COUNTY, for a period of three (3) years after final payment under the Agreement (Cal. Govt. Code Section 8546.7). CONTRACTOR shall participate in any audits and reviews, whether by COUNTY or the State, at no charge to COUNTY.

If federal, state, or COUNTY audit exceptions are made relating to this Agreement, CONTRACTOR shall reimburse all costs incurred by federal, state, and/or COUNTY governments associated with defending against the audit exceptions or performing any audits or follow-up audits, including but not limited to: audit fees, court costs, attorneys' fees based upon a reasonable hourly amount for attorneys in the community, travel costs, penalty assessments and all other costs of whatever nature. Immediately upon notification from COUNTY, CONTRACTOR shall reimburse the amount of the audit exceptions and any other related costs directly to COUNTY as specified by COUNTY in the notification.

CONTRACTOR shall also comply with the records, audit and review provisions set forth in EXHIBIT AA General Provisions: ADP/MHS to this Agreement.

15. INDEMNIFICATION AND INSURANCE.

CONTRACTOR agrees to and shall comply with the indemnification and insurance provisions as set forth in EXHIBIT C attached hereto and incorporated herein by reference.

16. NONDISCRIMINATION.

COUNTY hereby notifies CONTRACTOR that COUNTY's Unlawful Discrimination Ordinance (Article XIII of Chapter 2 of the Santa Barbara COUNTY Code) applies to this Agreement and is incorporated herein by this reference with the same force and effect as if the ordinance were specifically set out herein and CONTRACTOR agrees to comply with said ordinance. CONTRACTOR shall also comply with the nondiscrimination provisions set forth in EXHIBIT AA General Provisions: ADP/MHS to this Agreement.

17. NONEXCLUSIVE AGREEMENT.

CONTRACTOR understands that this is not an exclusive Agreement and that COUNTY shall have the right to negotiate with and enter into contracts with others providing the same or similar services as those provided by CONTRACTOR as the COUNTY desires.

18. NON-ASSIGNMENT.

CONTRACTOR shall not assign, transfer or subcontract this Agreement or any of its rights or obligations under this Agreement without the prior written consent of COUNTY and any attempt to so assign, subcontract or transfer without such consent shall be void and without legal effect and shall constitute grounds for termination.

19. TERMINATION.

A. By COUNTY. COUNTY may, by written notice to CONTRACTOR, terminate this Agreement in whole or in part at any time, whether for COUNTY's convenience, for nonappropriation of funds, or because of the failure of CONTRACTOR to fulfill the obligations herein.

- 1. For Convenience.** COUNTY may terminate this Agreement in whole or in part upon 30 days written notice. During the thirty (30) day period, CONTRACTOR shall, as directed by COUNTY, wind down and cease its services as quickly and efficiently as reasonably possible, without performing unnecessary services or activities and by minimizing negative effects on COUNTY from such winding down and cessation of services.
- 2. For Nonappropriation of Funds.** Notwithstanding any other provision of this Agreement, in the event that no funds or insufficient funds are appropriated or budgeted by federal, state or COUNTY governments, or funds are not otherwise available for payments in the fiscal year(s) covered by the term of

this Agreement, then COUNTY will notify CONTRACTOR of such occurrence and COUNTY may terminate or suspend this Agreement in whole or in part, with or without a prior notice period. Subsequent to termination of this Agreement under this provision, COUNTY shall have no obligation to make payments with regard to the remainder of the term.

3. **For Cause.** Should CONTRACTOR default in the performance of this Agreement or materially breach any of its provisions, COUNTY may, at COUNTY's sole option, terminate or suspend this Agreement in whole or in part by written notice. Upon receipt of notice, CONTRACTOR shall immediately discontinue all services affected (unless the notice directs otherwise) and notify COUNTY as to the status of its performance. The date of termination shall be the date the notice is received by CONTRACTOR, unless the notice directs otherwise.
- B. By CONTRACTOR.** Should COUNTY fail to pay CONTRACTOR all or any part of the payment set forth in EXHIBIT B(s), CONTRACTOR may, at CONTRACTOR's option terminate this Agreement if such failure is not remedied by COUNTY within 30 days of written notice to COUNTY of such late payment.
- C.** Upon termination, CONTRACTOR shall deliver to COUNTY all data, estimates, graphs, summaries, reports, and all other property, records, documents or papers as may have been accumulated or produced by CONTRACTOR in performing this Agreement, whether completed or in process, except such items as COUNTY may, by written permission, permit CONTRACTOR to retain. Notwithstanding any other payment provision of this Agreement, COUNTY shall pay CONTRACTOR for satisfactory services performed to the date of termination to include a prorated amount of compensation due hereunder less payments, if any, previously made. In no event shall CONTRACTOR be paid an amount in excess of the full price under this Agreement nor for profit on unperformed portions of service. CONTRACTOR shall furnish to COUNTY such financial information as in the judgment of COUNTY is necessary to determine the reasonable value of the services rendered by CONTRACTOR. In the event of a dispute as to the reasonable value of the services rendered by CONTRACTOR, the decision of COUNTY shall be final. The foregoing is cumulative and shall not affect any right or remedy which COUNTY may have in law or equity.

20. SECTION HEADINGS.

The headings of the several sections, and any Table of Contents appended hereto, shall be solely for convenience of reference and shall not affect the meaning, construction or effect hereof.

21. SEVERABILITY.

If any one or more of the provisions contained herein shall for any reason be held to be invalid, illegal or unenforceable in any respect, then such provision or provisions shall be deemed severable from the remaining provisions hereof, and such invalidity, illegality or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

22. REMEDIES NOT EXCLUSIVE.

No remedy herein conferred upon or reserved to COUNTY is intended to be exclusive of any other remedy or remedies, and each and every such remedy, to the extent permitted by law, shall be cumulative and in addition to any other remedy given hereunder or now or hereafter existing at law or in equity or otherwise.

23. TIME IS OF THE ESSENCE.

Time is of the essence in this Agreement and each covenant and term is a condition herein.

24. NO WAIVER OF DEFAULT.

No delay or omission of COUNTY to exercise any right or power arising upon the occurrence of any event of default shall impair any such right or power or shall be construed to be a waiver of any such default or an acquiescence therein; and every power and remedy given by this Agreement to COUNTY shall be exercised from time to time and as often as may be deemed expedient in the sole discretion of COUNTY.

25. ENTIRE AGREEMENT AND AMENDMENT.

In conjunction with the matters considered herein, this Agreement contains the entire understanding and agreement of the parties and there have been no promises, representations, agreements, warranties or undertakings by any of the parties, either oral or written, of any character or nature hereafter binding except as set forth herein. This Agreement may be altered, amended or modified only by an instrument in writing, executed by the parties to this Agreement and by no other means. Each party waives their future right to claim, contest or assert that this Agreement was modified, canceled, superseded, or changed by any oral agreements, course of conduct, waiver or estoppel. Any requests for changes to this Agreement by CONTRACTOR shall be in writing and submitted to COUNTY

before April 1 of the fiscal year for which the change would be applicable. Requests for changes failing to meet these requirements will not be considered. Notwithstanding any other provision of this Agreement, immaterial changes (such as changes to the Designated Representatives or addresses for purposes of Notice) as well as changes to this Agreement specified in the Exhibits may be authorized by the Director of the Department of Behavioral Wellness or designee in writing. These changes shall apply without the need for an amendment of this Agreement executed by the parties. All other changes shall be made by an amendment of this Agreement in compliance with this Section.

26. SUCCESSORS AND ASSIGNS.

All representations, covenants and warranties set forth in this Agreement, by or on behalf of, or for the benefit of any or all of the parties hereto, shall be binding upon and inure to the benefit of such party, its successors and assigns.

27. COMPLIANCE WITH LAW.

CONTRACTOR shall, at its sole cost and expense, comply with all federal, state, and local statutes; ordinances; regulations; orders including, but not limited to, executive orders, court orders, and health officer orders; policies; guidance; bulletins; information notices; and letters including, but not limited to, those issued by the California Department of Health Care Services (DHCS) now in force or which may hereafter be in force with regard to this Agreement. The judgment of any court of competent jurisdiction, or the admission of CONTRACTOR in any action or proceeding against CONTRACTOR, whether COUNTY is a party thereto or not, that CONTRACTOR has violated any such statute, ordinance, regulation, order, policy, guidance, bulletin, information notice, and/or letter shall be conclusive of that fact as between CONTRACTOR and COUNTY.

28. CALIFORNIA LAW AND JURISDICTION.

This Agreement shall be governed by the laws of the State of California. Any litigation regarding this Agreement or its contents shall be filed in the County of Santa Barbara, if in state court, or in the federal district court nearest to Santa Barbara County, if in federal court.

29. EXECUTION OF COUNTERPARTS.

This Agreement may be executed in any number of counterparts and each of such counterparts shall for all purposes be deemed to be an original; and all such counterparts, or as many of them as the parties shall preserve undestroyed, shall together constitute one and the same instrument.

30. AUTHORITY.

All signatories and parties to this Agreement warrant and represent that they have the power and authority to enter into this Agreement in the names, titles and capacities herein stated

and on behalf of any entities, persons, or firms represented or purported to be represented by such entity(ies), person(s), or firm(s) and that all formal requirements necessary or required by any state and/or federal law in order to enter into this Agreement have been fully complied with. Furthermore, by entering into this Agreement, CONTRACTOR hereby warrants that it shall not have breached the terms or conditions of any other contract or agreement to which CONTRACTOR is obligated, which breach would have a material effect hereon.

31. SURVIVAL.

All provisions of this Agreement which by their nature are intended to survive the termination or expiration of this Agreement shall survive such termination or expiration.

32. PRECEDENCE.

In the event of conflict between the provisions contained in the numbered sections of this Agreement and the provisions contained in the Exhibits, the provisions of the Exhibits shall prevail over those in the numbered sections.

33. BUSINESS ASSOCIATE. (RESERVED)

THIS SECTION LEFT BLANK INTENTIONALLY.

SIGNATURE PAGE FOLLOWS.

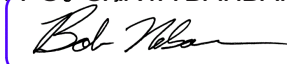
SIGNATURE PAGE

SIGNATURE PAGE

Agreement for Services of Independent Contractor between the **County of Santa Barbara** and Casa Pacifica Centers for Children and Families.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on July 1, 2026.

COUNTY OF SANTA BARBARA

Signed by: 
By: 9DD6B7A21FC646A...
Bob Nelson, CHAIR
Board of Supervisors
Date: 6/29/2026 | 10:37 AM PDT

ATTEST:
Mona Miyasato
County Executive Officer
Clerk of the Board

Signed by: 
By: 0B03E3DDE9EE4AA...
Deputy Clerk
Date: 6/29/2026 | 10:48 AM PDT

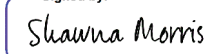
APPROVED AS TO FORM:
RACHEL VAN MULLEM
COUNTY COUNSEL

Signed by: 
By: 48A252DEFFD3466...
Deputy County Counsel

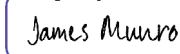
RECOMMENDED FOR APPROVAL:
Antonette Navarro, LMFT Director,
Department of Behavioral Wellness

DocuSigned by: 
By: 2095C5A16FE1474...
Director

CONTRACTOR:
CASA PACIFICA CENTERS FOR
CHILDREN AND FAMILIES

Signed by: 
By: ADEF66E32CD84D8...
Authorized Representative
Name: Shawna Morris
Title: Chief Executive Officer
Date: 6/10/2026

APPROVED AS TO ACCOUNTING FORM
BETSY M. SCHAFFER, CPA
AUDITOR-CONTROLLER

Signed by: 
By: 02BA147EF6A84DE...
Deputy

APPROVED AS TO FORM:
Marisa Kahn, Risk Manager,
Risk Management

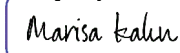
Signed by: 
By: DF54F5C66F0C41A...
Risk Manager

EXHIBIT A

STATEMENT OF WORK

MHS SERVICES

**EXHIBIT A-1 MHS
STATEMENT OF WORK:
SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAM**

- 1. PROGRAM SUMMARY.** Contractor shall provide short-term residential therapeutic program (STRTP) mental health services to children and youth (9 -19 years of age) members (defined in Section 6 [Members] of this Exhibit) (hereafter, Program). Contractor shall comply with all applicable requirements set forth in Exhibit AA General Provisions: ADP/MHS of this Agreement.
- 2. PROGRAM OBJECTIVES.** The objectives of the Program are to:
 - A.** Provide the appropriate level of mental health services support for members who have been removed from their homes by a juvenile court; and
 - B.** Effectively treat identified mental health condition(s) by building upon the member's strengths and reducing functional impairments to support transition to a lower level of care.
- 3. SERVICES.**
 - A.** The Program shall include the following services as described in Section II Program Service Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement:
 - 1.** Assessment/reassessment;
 - 2.** Collateral;
 - 3.** Crisis intervention;
 - 4.** Intensive care coordination;
 - 5.** Medication support services;
 - 6.** Peer support services
 - 7.** Psychosocial rehabilitation;
 - 8.** Targeted case management;
 - 9.** Therapy; and
 - 10.** Treatment planning.
 - B. Short-Term Residential Therapeutic Program.**
 - 1.** Short-Term Residential Therapeutic Programs (STRTP) are licensed by the California Department of Social Services and provided a Mental Health

Program Approval by the Department of Health Care Services. STRTPs are residential facilities that provide an integrated program of specialized and intensive care and supervision, services and supports, specialty mental health services, mental health treatment; and short-term, 24-hour care and supervision to children

2. Members receiving Program services shall live on the Program premises.
 3. Contractor shall provide the service components listed in Section 3.A of this Exhibit to members in accordance with all of the following: a member's individualized treatment plan, the assessment completed by a qualified individual (QI), the certification for referral by the Interagency Placement Committee (IPC), and any updates or addendums thereto.
 4. Contractor shall maintain the level of care and services necessary to meet the needs, including the assessed needs and child specific goals identified by a QI, as applicable, of members.
 5. Contractor may provide certain service components to members following admission into and as informed by the Qualified Individual and pending completion of a member's treatment plan as set forth in Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit.
 6. The average length of treatment for a member shall not exceed six months. Notwithstanding, the length of treatment for a member may be extended beyond six months if approved by Santa Barbara County Child Welfare Services or Santa Barbara County Probation in collaboration with the member's Child and Family Team (CFT), Program staff and the IPC.
4. **ADDITIONAL SERVICE REQUIREMENTS.** Contractor shall provide additional services that do not alter the maximum contract amount of this Agreement and are authorized by the Director of the Department of Behavioral Wellness or designee in writing in accordance with Section 25 (Entire Agreement and Amendment) of the Standard Terms and Conditions of this Agreement.
5. **OPERATIONS.**
- A. **Licensure/Certification.** Contractor shall be licensed as a short-term residential therapeutic program by the California Department of Social Services, Community Care and Licensing Division in accordance with [Short-Term Residential Therapeutic Program: Interim Licensing Standards ver. 5](#). Additionally, Contractor shall be Medi-Cal certified by the California Department of Health Care Services to provide specialty mental health services.

B. Location. The Program shall be located at the following location(s):

1. 1722 South Lewis Road, Camarillo, CA

C. Hours of Operation and Staff Coverage. Program staff shall be available to provide Program services to members 24 hours a day, seven days a week as needed.

D. Capacity. The Program is licensed to serve up to 10 members.

6. MEMBERS.

A. Contractor shall provide short-term residential treatment program specialty mental health services to children and youth (9–19 years of age) who meet Medi-Cal eligibility and residency or county of responsibility requirements and meet medical necessity.

B. Program admission requirements are more fully described in Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit. (Collectively, members.)

C. Contractor's provision of services to members under this Program shall not exceed the funding levels projected in Exhibit B-1 MHS.

7. REFERRALS.

A. Referral Source and Procedure. Contractor shall receive referrals for placement of children and youth (9-19 years of age) at the Program and referral documentation/placement packets from Santa Barbara County Child Welfare Services, Santa Barbara County Probation, or another Santa Barbara County placing agency (Santa Barbara County placing agency).

B. Referral Documentation. Contractor shall work directly with the referral source to obtain referral documentation required by Contractor to screen referred children and youth for Program services eligibility.

8. AUTHORIZATION, ADMISSSION, INTAKE, AND REAUTHORIZATON.

A. Medi-Cal Eligibility and Residency or County of Responsibility. Contractor shall verify each referred child or youth's Medi-Cal eligibility and Santa Barbara County residency as described in Section IV Administrative Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement.

B. Medically Necessary or Medical Necessity. STRTP services shall be medically necessary as described in Section II Program Service Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement.

C. Review of Referral Documentation/Placement Packet. Upon receipt of referral documentation/placement packets from a Santa Barbara County placing agency, Contractor shall review the documentation/packet. Contractor's review shall include review of the QI assessment and the IPC certification for referral.

- 1. Qualified Individual Assessment.** A Qualified Individual (QI) must complete an independent assessment, under Welfare and Institutions Code section 4096, 30 calendar days from the date of the QI referral from the placing agency or from the date the member is placed into an STRTP, whichever comes first. The QI shall determine whether the member's needs can instead be met with family members, in a tribally approved home in the case of an Indian child, or in another family-based setting. The QI's determination also documents why a STRTP is the most appropriate level of care and recommends treatment services and interventions for the member. As implemented in Assembly Bill 153 under Welfare and Institutions Code section 4096, subdivision (g)(3)(B), the QI assessment must be completed using an age-appropriate, evidence-based, validated, functional assessment tool. California has chosen the Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS) tool as a component of the QI assessment.
- 2. Interagency Placement Committee.** Counties establish an IPC with a membership that includes at least the county placement agency and a licensed mental health professional from the county department of mental health. An IPC institutes procedures whereby a child meeting the criteria specified in WIC Section 4096(e)(1) may be placed into an STRTP. The IPC has served as a way to identify the placement with the most appropriate level of care and services. The IPC requirements pursuant to WIC Sections 4096 and 11, the IPC determines a child's eligibility for STRTP placement pursuant to WIC Section 4096(e)(1), and determines the specific placement facilities or programs that have the capacity to address the needs of the child as specified in WIC Section 4096(e)(2).

D. Admission.

- 1.** Contractor shall admit children and youth into the Program meeting all of the following admission criteria unless one or more of the conditions specified in Section 9 (Exclusion Criteria) of this Exhibit applies, or space is not available in the Program in accordance with Subsection D (Capacity), Section 5 (Operations) of this Exhibit or otherwise:

- i. The child or youth was referred for placement by a Santa Barbara County placing agency.
- ii. The child or youth meets Medi-Cal eligibility and Santa Barbara County residency requirements.
- iii. The child or youth's QI assessment recommends placement in a STRTP level of care.
- iv. The child or youth's IPC certification for referral includes a certification that the child or youth meets medical necessity criteria for Medi-Cal specialty mental health services.

2. Notice of Admission Decision.

- i. If a child or youth referred for placement is admitted into the Program, Contractor shall notify the Santa Barbara County placing agency and the Department of Behavioral Wellness no later than five business days of the decision to admit.
- ii. If a child or youth referred for placement is not admitted into the Program due to not meeting admission criteria, one or more of the conditions specified in Section 9 (Exclusion Criteria) of this Exhibit applies, or space is not available in the Program in accordance with Subsection D (Capacity), Section 5 (Operations) of this Exhibit or otherwise, Contractor shall notify the Santa Barbara County placing agency and the Department of Behavioral Wellness immediately and no later than one business day of the decision to deny admission. Contractor shall also notify the child or youth of the exclusion from the Program in compliance with *Department Policy #4.010 Notice of Adverse Benefit Determination*.

E. Emergency Placement.

- 1. Contractor shall place children and youth into the Program under emergency placement meeting all of the following emergency placement criteria unless one or more of the conditions specified in Section 9 (Exclusion Criteria) of this Exhibit applies, or space is not available in the Program in accordance with Subsection D (Capacity), Section 5 (Operations) of this Exhibit or otherwise:
 - i. The child or youth was referred for placement by a Santa Barbara County placing agency.
 - ii. The child or youth meets Medi-Cal eligibility and Santa Barbara County residency requirements.

- iii. The child or youth requires emergency placement in a STRTP level of care prior to the determination by the QI assessment and IPC certification for referral.
- iv. A licensed mental health professional has made a written determination within 72 hours of the child or youth's placement that the child or youth requires the level of services and supervision provided by the Program in order to meet their behavioral or therapeutic needs in compliance with *Department Policy # 8.205 Short-Term Therapeutic Programs (STRTP) Placement and Role of Interagency Placement Committees (IPC)*.

2. Notice of Placement Decision.

- i. If a child or youth referred for placement is placed into the Program under emergency placement, Contractor shall notify the Santa Barbara County placing agency and the Department of Behavioral Wellness no later than five business days of the decision to place.
- ii. If a child or youth referred for placement is not placed into the Program under emergency placement due to not meeting emergency placement criteria, one or more of the conditions specified in Section 9 (Exclusion Criteria) of this Exhibit applies, or space is not available in the Program in accordance with Subsection D (Capacity), Section 5 (Operations) of this Exhibit or otherwise, Contractor shall notify the Santa Barbara County placing agency and the Department of Behavioral Wellness immediately and no later than one business day of the decision to deny emergency placement. Contractor shall also notify the child or youth of the exclusion from the Program in compliance with *Department Policy #4.010 Notice of Adverse Benefit Determination*.

3. Admission Following Emergency Placement. In the case of children or youth placed in the Program under emergency placement:

- i. Contractor shall review the QI assessment and IPC certification for referral upon receipt.
- ii. Contractor shall admit children or youth into the Program meeting the admission criteria in Subsection C.1 of this Section (Authorization, Admission, Intake, Reauthorization).
- iii. If the QI assessment does not recommend placement in a STRTP level of care, or if the IPC does not certify the referral or the IPC certification for referral does not include a certification that the child or youth meets

medical necessity criteria for Medi-Cal specialty mental health services, Contractor shall discharge the child or youth from the Program in accordance with Section 11 (Discharge) of this Exhibit.

- iv. Contractor shall provide notice of the admission decision following emergency placement in accordance with Subsection C.2 (Notice of Admission Decision) of this Section (Authorization, Admission, Intake, and Reauthorization).

F. Services Pending Member Treatment Plan. Upon the referred child or youth's admission into the Program, and until a member treatment plan is assigned, Contractor is authorized to provide the following services during the first 30 days of admission into the Program:

1. Assessment;
2. Treatment plan;
3. Crisis intervention;
4. Medication support; and
5. Intensive care coordination.

G. Member Treatment Plan.

1. Except as provided in Subsection E (Services Pending Member Treatment Plan) of this Section (Authorization, Admission, Intake, and Reauthorization), Contractor shall ensure each member has an individualized member treatment plan, based on the QI assessment and IPC referral, and it is in SmartCare prior to the provision of services in accordance with the MHP Required Documentation available at [CalAim Documentation Reform SmartCare & Documentation Resources | Santa Barbara County, CA - Official Website](#) and Medi-Cal and other applicable federal, state, and local laws, rules, manuals, policies, guidelines, and directives.
2. Contractor shall ensure care planning is an ongoing, interactive component of services delivery to identify member strengths, problems, and interventions to support the member in setting and attaining goals towards recovery.
3. Contractor shall ensure care planning considers QI recommendations and IPC certification for referral recommendations and any updates or amendments thereto in accordance with applicable state and federal privacy laws including the member's release of information or consent and the

confidentiality of juvenile case records under Welfare and Institutions Code section 827.

4. Contractor shall produce and communicate the content of the member treatment plan to the member, other providers, and Medi-Cal behavioral health delivery systems to support the delivery of coordinated care in accordance with applicable state and federal privacy laws.
5. The member treatment plan shall provide overall direction for the collaborative work of the member, the Program, and the treatment team. The member treatment plan shall include:
 - i. Recovery goals which will guide the service delivery process;
 - ii. Objectives describing the skills and behaviors that the member will be able to learn as a result of the Program's behavioral interventions; and
 - iii. Interventions planned to help the member reach the member's goals.

H. Reauthorization.

1. Contractor shall collaborate with the Santa Barbara County Placing Agency and IPC regarding ongoing recommendations or ongoing authorization or recommended step down from the Program.

2. Placement Disruptions.

- i. Should there be a placement disruption of a child or youth who was admitted into the Program, the Contractor shall inform the Santa Barbara County placing agency, CWS/Probation, as the agency responsible for monitoring the child/youth overall on behalf of the juvenile court, and Behavioral Wellness Staff. The IPC provides updates to the Contractor on any placement changes.
- ii. Should the member return to the Program, Contractor shall inform Behavioral Wellness Staff and the placing agency (CWS or Probation).

I. Presumptive Transfer or Change in Member's County of Responsibility.

1. If at any point in a member's admission or emergency placement in the Program, either of the circumstances under Welfare and Institutions Code section 14717.2, subdivision (b)(1) or (2) exist as to the member, the process for presumptive transfer set forth in Welfare and Institutions Code section 14717.1 shall apply. (See, also, BHIN 24-025.)

2. The Santa Barbara County placing agency shall convene one or more CFT meeting(s) to document that presumptive transfer applies to the member under Welfare and Institutions Code section 14717.2, subdivision (b)(1) or (2); there has been no waiver of presumptive transfer under Welfare and Institutions Code section 14717.1; and the agreed upon presumptive transfer date.
3. Prior to the presumptive transfer date, Santa Barbara County Department of Behavioral Wellness shall maintain responsibility for the authorization and provision of specialty mental health services.
4. Upon presumptive transfer, the mental health plan in the county in which the member resides shall assume responsibility for the authorization and provision of specialty mental health services.

9. EXCLUSION CRITERIA.

- A. On a case-by-case basis, children or youth referred for admission into the Program or members admitted into the Program may be excluded from the Program. The following may be cause for exclusion from the Program:
 1. Threatening or violence towards staff or other members;
 2. Rude or disruptive behavior that cannot be redirected; and
 3. Not meeting medical necessity criteria in accordance with Section 6 Members and Section 8 Authorization, Admissions, Intake and Reauthorization of this Agreement.
- B. Contractor shall notify the child or youth referred for admission into the Program or members admitted into the Program of the exclusion from the Program in compliance with *Department Policy #4.010 Notice of Adverse Benefit Determination*.

10. DOCUMENTATION REQUIREMENTS. (Reserved)

11. **DISCHARGE.** On a case-by-case basis, members admitted into the Program may or must be discharged from the Program as follows:

- A. **Permissive Discharge.** Contractor may discharge a member from the Program if a determination is made, in collaboration with the member's CFT, that:
 1. The member's treatment goals have been met;

2. Significant progress has been made towards reaching the member's treatment goals, even if not all goals have been met, such that the member no longer requires the intensive level of services provided by the Program; or
3. The member's treatment goals have not been met, and the member no longer needs, or is not benefiting from, placement in the Program.

B. Discharge. Contractor shall discharge a member from the Program as follows:

1. The IPC determines, with recommendations from the member's CFT and/or the QI, that the member is not appropriately placed in the Program and disapproves of the placement in writing and the Contractor makes a plan with the placing agency for linkage to an appropriate placement; or
2. The Santa Barbara County placing agency opines that the member is not appropriately placed in the STRTP level of care or Program.

C. Discharge Plan and Continuity of Care. Within 30 days of a member's anticipated discharge date, Contractor shall, in collaboration with the member's CFT, prepare a written discharge plan that is responsive to the member's needs and personal goals. Contractor shall provide transportation to joint treatment sessions during the member's transition to another provider. Contractor shall comply with *Department Policy # 8.303 Member Discharge and Continuity of Care for Mental Health Services*.

12. NON-REIMBURSEMENT. (Reserved)

13. REPORTING AND MONITORING. (Reserved)

14. STAFFING. Contractor shall staff the Program with provider types and qualifications in compliance with California State Plan Amendment 23-006, BHIN 24-023, and the concomitant amendments to titles 9 and 22 of the California Code of Regulations. Contractor may utilize provider types for the delivery of services under this Program as set forth in the applicable Specialty Mental Health Service Table at [MedCCC - Library](#).

15. GOALS, OUTCOMES, AND MEASURES. (RESERVED)

**EXHIBIT A-2 MHS
STATEMENT OF WORK:
INTENSIVE HOME-BASED SERVICES, INTENSIVE CARE COORDINATION,
AND THERAPEUTIC BEHAVIORAL SERVICES**

- 1. PROGRAM SUMMARY.** Contractor shall provide the following services to children and youth (collectively, under 21 years of age) members (defined in Section 6 [Members] of this Exhibit) (hereafter, Program):
 - A.** Intensive home based services (IHBS),
 - B.** Intensive care coordination (ICC), and
 - C.** Therapeutic behavioral services (TBS).
 - D.** Contractor shall comply with all applicable requirements set forth in Exhibit AA General Provisions: ADP/MHS of this Agreement.
- 2. PROGRAM OBJECTIVES.** The objectives of the Program are to:
 - A.** Maintain the member’s residential placement at the lowest appropriate level by resolving identified problem behaviors and achieving short-term treatment goals.
- 3. SERVICES.** The Program shall include the following services as further described in Section II Program Service Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement:
 - A. IHBS and ICC.** IHBS and ICC are designed to help members and their parents or caregivers manage challenging behaviors by utilizing short-term, measurable goals based on the individualized needs of the member and family. IHBS and ICC are provided to members in conjunction with other medically necessary specialty mental health services.
 - B. Intensive Home Based Services.** “Intensive Home Based Services (IHBS)” are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child’s functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child’s family’s ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family’s overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, treatment plan, therapy, rehabilitation and include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of

the member. IHBS is provided to members under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.

- 1. Service Intensity.** Contractor shall provide IHBS to members in the amount, scope, and duration authorized by the Department of Behavioral Wellness Quality Care Management (QCM). (See Subsection B.2.iii of Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit.) Contractor shall provide ICC to members who receive IHBS at minimum every three months.

C. Intensive Care Coordination. “Intensive Care Coordination (ICC)” is a targeted case management service that facilitates assessment of care planning for and coordination of services to members under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical criteria to access SMHS. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:

- 1.** Ensures that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family-child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the member;
- 2.** Facilitates a collaborative relationship among the member, their family, and systems involved in providing services to the member;
- 3.** Supports the parent/caregiver in meeting the member’s needs;
- 4.** Helps establish the CFT and provides ongoing support; and
- 5.** Organizes and matches care across providers and child-serving systems to allow the member to be served in their community.

- D.** If a Contractor does not provide TBS, Contractor shall coordinate and link members who are eligible for TBS to a County-contracted TBS provider within seven business days of the determination of eligibility.

E. Therapeutic Behavioral Services.

1. Therapeutic behavioral services are intensive, one-to-one services designed to help members and their parents or caregivers manage specific behaviors using short-term measurable goals based on the member's needs and are SMHS covered EPSDT (9 CCR section 1810.215 and DMH Information No. 08-38).
2. TBS are designed to help children/youth and parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the needs of the child/youth and family.
3. TBS are never a stand-alone therapeutic intervention. It is used in conjunction with another mental health service.

- F. Child Family Team.** The CFT is comprised of, as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy, and all ancillary individuals who work together to develop and implement the individualized member service plan and are responsible for supporting the member and family in attaining their goals.

1. Contractor shall facilitate, coordinate, and participate in Department of Behavioral Wellness CFT meetings for each member to review the member's progress and services every 30 days. Department of Behavioral Wellness CFT participants shall include the member (whose participation is preferred but not required), the member's parent or guardian, Contractor and Department of Behavioral Wellness staff, and anyone who else may be able to contribute to the individualized member service plan.

4. ADDITIONAL SERVICE REQUIREMENTS. (Reserved)

5. OPERATIONS.

- A. Location.** The Program shall be located at the following location(s):

1. 2605 S. Miller St., Suite 101, Santa Maria, California;
2. 120 Cremona Dr., Suite 220, Goleta, California.

- B. Service Settings and Hours and Staff Coverage.** Contractor shall provide Program services to members in their homes or communities throughout Santa

Barbara County. Program staff shall be available to provide Program services to members up to 24 hours a day as needed.

- C. Program Capacity.** The target census for provided services, described in Section 3 (Services), is 80 members. Should numbers fall below 60 members, the Contactor shall notify BWell.

6. MEMBERS.

- A.** Contractor shall provide IHBS, ICC, and TBS services to children and youth (collectively, under 21 years of age) who meet Program services eligibility requirements and services authorization and reauthorization requirements in the case of IHBS and TBS in Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit (hereafter, members).
- B.** Program admission requirements are more fully described in Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit. (Collectively, members.)
- C.** Contractor's provision of services to members under this Program shall not exceed the funding levels projected in Exhibit B-1 MHS.

7. REFERRALS.

- A. Referral Procedure.** Contractor shall accept referrals for the screening of children and youth (collectively, under 21 years of age) for Program services eligibility from the child or youth's CFT.
- B. Referral Documentation/Package.** Contractor shall work directly with the referred child or youth's CFT to obtain the following referral documentation/package and any other information or documentation required to screen the child or youth for Program services eligibility:
 1. Completed IHBS, ICC, or TBS referral form;
 2. The Medi-Cal eligibility database sheet (MEDS) for the child or youth; and
 3. A current comprehensive or updated assessment for the child or youth that documents eligibility criteria for IHBS, ICC, or TBS.

8. AUTHORIZATION, ADMISSION, INTAKE, AND REAUTHORIZATION.

- A. Medi-Cal Eligibility and Residency or County of Responsibility.** Contractor shall verify each referred child or youth's Medi-Cal eligibility and Santa Barbara County residency or county of responsibility as described in Section IV

Administrative Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement.

- B. Timely Access to Services.** In accordance with 42 Code of Federal Regulations (C.F.R.) section 438.206, Contractor shall meet standards for timely access to care and services, taking into consideration the urgency of need for services. Contractor shall attempt to provide first service for routine referrals within 10 business days and within 48 hours for referrals determined to be urgent as outlined in *Department Policy # 2.001 Network Adequacy Standards and Monitoring*.
- C. Medically Necessary or Medical Necessity.** IHBS, ICC and TBS shall be medically necessary as described in Section II Program Service Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement.
- D. IHBS and ICC Eligibility Authorization and Reauthorization.** County or contracted providers shall determine eligibility of each referred child or youth's for IHBS and ICC as determined by the assessment. Only County QCM with authorize the referral and determine of the members meets the following criteria:
- 1. IHBS and ICC Eligibility.** To be eligible for IHBS or ICC, the referred child or youth must meet the following eligibility requirements:
 - i. Under the age of 21;
 - ii. Eligible for the full scope of Medi-Cal services; and
 - iii. Meets medical necessity criteria in accordance with Welfare and Institutions Code sections 14059.5 and 14184.402 and title 9 California Code of Regulations sections 1830.
 - 2. Department of Behavioral Wellness Quality Care Management Authorization and Reauthorization Procedure for IHBS.**
 - i. IHBS Authorization Request. Contractor shall submit initial authorization requests for IHBS to the Department of Behavioral Wellness QCM using the IHBS Authorization Request Form specified in *Department Policy # 8.203 Intensive Mental Health Services for Youth*. Contractor shall simultaneously submit the following documentation in support of the authorization request:
 - a. Completed IHBS Referral form.
 - b. Reference to a current Comprehensive or Updated Assessment that documents the criteria for IHBS.

- c. Member's Medi-Cal Eligibility Database Sheet (MEDS).
 - ii. IHBS Reauthorization Request. At least five business days prior to the expiration of an existing IHBS authorization by the Department of Behavioral Wellness QCM for a member, Contractor shall document the reauthorization criteria in the member's health record and submit a reauthorization request for IHBS to the Department of Behavioral Wellness QCM using the IHBS Reauthorization Request Form specified in *Department Policy # 8.203 Intensive Mental Health Services for Youth*.
 - iii. Department of Behavioral Wellness QCM Response to IHBS Authorization or Reauthorization Request. The Department of Behavioral Wellness QCM will respond to initial or reauthorization requests for IHBS in the timeframe specified in *Department Policy # 8.203 Intensive Mental Health Services for Youth*: generally, as expeditiously as the referred child or youth's or member's mental health condition requires and not to exceed five business days. The Department of Behavioral Wellness QCM's response to IHBS authorization or reauthorization requests will be in writing and, if the IHBS authorization or reauthorization request is approved, will include the authorized amount, scope, and duration of IHBS treatment.
3. **Admission.** Contractor shall provide IHBS and ICC to referred children and youth meeting IHBS and ICC eligibility requirements and IHBS authorization and reauthorization requirements unless one or more of the conditions specified in Section 9 (Exclusion Criteria) of this Exhibit applies.
 4. **Admission Documentation.** At Contractor's intake meeting with each member admitted into the Program, Contractor shall complete admission documentation with the following information:
 - i. Informed Consent to Treatment form, signed by authorized caregiver.
 - ii. Release of Information form, signed by signed by authorized caregiver.
 5. **Notice of Adverse Benefit Determination: Exclusion.** If a child or youth referred for IHBS or ICC is excluded from the Program due to the applicability of one or more of the conditions specified in Section 9 (Exclusion Criteria) of this Exhibit, Contractor shall notify the child or youth of the exclusion from the Program in compliance with *Department Policy #4.010 Notice of Adverse Benefit Determination*.

6. Notice of Adverse Benefit Determination: Denial of Authorization or Not Medically Necessary.

- i. If the Department of Behavioral Wellness QCM denies an authorization request for IHBS or authorizes IHBS in an amount, duration, or scope less than that requested by the member and Contractor, Department of Behavioral Wellness QCM will issue a written Notice of Adverse Benefit Determination to the member and Contractor.
- ii. If Contractor determines that medical necessity criteria for IHBS or ICC has not been met, Contractor shall notify the referred child or youth or member of the determination in accordance with 42 Code of Federal Regulations (C.F.R.) section 438.404 and *Department Policy #4.010 Notice of Adverse Benefit Determination*.

E. Department of Behavioral Wellness Quality Care Management Authorization and Reauthorization Procedure for TBS.

- 1. TBS Authorization Request.** Contractor shall submit initial authorization requests for TBS to the Department of Behavioral Wellness QCM using the Authorization Request Form specified in *Department Policy # 8.203 Intensive Mental Health Services for Youth*. Contractor shall simultaneously submit the following documentation in support of the authorization request:
 - i. Completed IHBS Referral form.
 - ii. Reference to a current Comprehensive or Updated Assessment that documents the criteria for IHBS.
 - iii. Member's Medi-Cal Eligibility Database Sheet (MEDS)
- 2. TBS Eligibility.** Contractor shall determine each referred child or youth's eligibility for TBS. To be eligible for TBS, the referred child or youth must meet general specialty mental health services eligibility requirements, class action member eligibility requirements, and TBS needs eligibility requirements. To be eligible for TBS, the referred child or youth must meet the following general specialty mental health services eligibility requirements:
 - i. Under the age of 21;
 - ii. Eligible for the full scope of Medi-Cal services; and
 - iii. Meets medical necessity criteria in accordance with Welfare and Institutions Code sections 14059.5 and 14184.402 and title 9 California Code of Regulations sections 1830.

- 3. Membership in the Certified Class.** To be eligible for TBS, the referred child or youth must qualify as a member of the certified class by meeting at least one of the following class action member eligibility requirements:
 - i. The child or youth is placed in a residential facility at the short-term residential therapeutic program (STRTP)-level or higher and/or a locked treatment facility for the treatment of mental health needs;
 - ii. The child or youth is being considered for placement in these facilities section 2.i;
 - iii. The child or youth has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months; or
 - iv. The child or youth had previously received TBS while a member of the certified class.
- 4. Need for TBS.** To be eligible for TBS, the referred child or youth must have a need for TBS based upon the following TBS needs requirements:
 - i. The child or youth is receiving other specialty mental health services;
 - ii. The clinical judgment of the Contractor indicates that it is highly likely that without the additional short-term support of TBS that:
 - a. The child or youth will need to be placed out-of-home or into a higher level of residential care, including acute care, because of the child or youth's behaviors or symptoms which jeopardize continued placement in the current placement ("acute care" includes acute psychiatric hospital inpatient services, psychiatric health facility services, and crisis residential treatment services); or
 - b. The child or youth needs this additional support to transition to a home or foster home or lower level of residential placement (Although the child or youth may be stable in the current placement, a change in behavior or symptoms is expected, and TBS are needed to stabilize the child or youth in the new environment. Contractor must document the basis for the expectation that the behavior or symptoms will change).
- 5. Notice of Adverse Benefit Determination.** If Contractor determines that medical necessity criteria or other eligibility criteria for TBS has not been met, Contractor shall notify the referred child or youth of the determination in accordance with 42 Code of Federal Regulations (C.F.R.) section 438.404 and *Department Policy #4.010 Notice of Adverse Benefit Determination*.

9. EXCLUSION CRITERIA.

A. On a case-by-case basis, children or youth referred for admission into the Program or members admitted into the Program may be excluded from the Program. The following may be cause for exclusion from the Program:

1. Threatening or violence towards staff or other members;
2. Rude or disruptive behavior that cannot be redirected; and
3. Not meeting medical necessity criteria in accordance with Title 22 C.C.R. Sections 51303, Welfare and Institutions Code sections 14184.402, subd. (a) and 14059.5 and BHINs 21-071, 23-001 and 23-068.

B. Notice of Adverse Benefit Determination: Exclusion. Contractor shall notify the child or youth referred for admission into the Program or members admitted into the Program of the exclusion from the Program in compliance with *Department Policy #4.010 Notice of Adverse Benefit Determination*.

10. DOCUMENTATION REQUIREMENTS. Contractor shall document and maintain ICC/IHBS/TBS Assessments and Member Service Plans in accordance with any and all State requirements. The County shall complete the ICC/IHBS/TBS Assessment and Member Service Plan within 30 days prior to initiating services or activating referrals.

A. Member Treatment Plan.

1. Contractor shall ensure care planning is an ongoing, interactive component of services delivery to identify members strengths, problems, and interventions to support the member in setting and attaining goals towards recovery.
 - i. Contractor shall adhere to all relevant care planning requirements in accordance with applicable state and federal privacy law.
 - ii. Contractor shall document the required elements of the care plan within the member record within an electronic health record.
 - iii. To support delivery of coordinated care, the Contractor shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy law.
 - iv. For specific services, with additional requirements, Contractor shall follow Enclosure 1a: *Care Planning Requirements that Remain in Effect* in

in [BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf](#).

B. Member Treatment Plan Requirements. The Member Treatment Plan shall meet Medi-Cal and other applicable Federal, State and local laws, rules, manuals, policies, guidelines, and directives. The Member Treatment Plan shall include:

1. The member's recovery goals, which guide the service delivery process;
2. Objectives describing the skills and behaviors that the member will be able to learn as a result of the Program's behavioral interventions; and
3. Interventions planned to help the member reach the member's goals.

C. ICC/IHBS/TBS Member Service Plan. Contractor shall document and maintain ICC/IHBS/TBS Assessments and Member Service Plans in accordance with any and all State requirements. The County shall complete the ICC/IHBS/TBS Assessment and Member Service Plan within 30 days prior to initiating services or activating referrals.

1. The Treatment Team shall complete a Member Service Plan in collaboration with Contractor for each member receiving Program services in accordance with the Behavioral Wellness Clinical Documentation Manual available at [County of Santa Barbara Behavioral Wellness](#). The Member Service Plan shall provide overall direction for the collaborative work of the member, the Program staff, and the Treatment Team.
2. **TBS Member Treatment Plan.** The TBS Member Treatment Plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the member as identified by the assessment process. TBS must be identified as an intervention on the overall Behavioral Wellness Treatment Plan; TBS is not a stand-alone service. TBS Member Plans must include all the following:
 - i. Specific behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement;
 - ii. Specific plan of intervention for each of the targeted behaviors or symptoms identified in the Comprehensive Assessment and the Behavioral Wellness Treatment Plan;
 - iii. Specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for those changes; and

iv. Specific outcome measures that can be used to demonstrate the effectiveness of the intervention at regular levels and documentation of changes in planned interventions when the original plans are not achieving expected results.

a. For members between ages 18 and 21, Contractor staff notes regarding any special considerations that should be considered shall be included in the TBS Member Plan, such as the identification of an adult case manager.

b. When applicable, TBS Member Plans must include a plan for transition to adult services when the member turns 21 years old and is no longer eligible for TBS. This transition plan shall address the skills and strategies that assisting parents/caregivers will need to provide for continuity of care when member's TBS is discontinued.

3. TBS Member Plan Addendum. A TBS Member Plan Addendum shall be used to document the following:

i. Significant changes in the member's environment since the initial development of the TBS Member Plan; and

ii. When TBS has not been effective and the member is not progressing as expected towards the identified goals, there must be documented evidence in the member chart and Discharge Plan and any additional information indicating the consideration of alternative interventions or treatment options.

4. TBS Progress Notes. Progress notes are required each day TBS is delivered and must include a comprehensive summary covering the time that services were provided. The Contractor shall ensure each Progress Note clearly documents the following:

i. Occurrences of specific behaviors and/or symptoms that threaten the stability of the current residential placement or prevent transition to a lower level of residential placement;

ii. Delivery of significant interventions identified in the TBS Member Plan; and

iii. Progress in stabilizing behaviors and/or symptoms by changing or eliminating maladaptive behaviors and replacing them with adaptive behaviors.

11. DISCHARGE.

A. Discharge Criteria. From the onset of services, a titration plan shall be incorporated in the IHBS/ICC treatment plan to support the member/family in independently managing behaviors so that service delivery from the Contractor will decrease as discharge approaches.

1. The appropriateness for member discharge shall be determined on a case by case basis. Criteria for discharge if the member's treatment goals have been sufficiently met and shall include the following:

- i. The determination that the member's treatment goals have not been met, as determined by the CFT Treatment Team and Program staff. The member and family shall be provided with appropriate continuity of care and coordination of care through transition or referrals to more appropriate treatment;
- ii. The determination that significant progress towards reaching the member's treatment goals has been made, even if not all goals have been met, such that the member no longer requires the intensive level of services provided by the Program;
- iii. Member/family's circumstances have changed, and the member is no longer eligible for services; and
- iv. Relocation of the member and family outside of Santa Barbara County.

B. Contractor shall follow Behavioral Wellness policy #8.303 Member Discharge and Continuity of Care for Mental Health Services regarding discharges in conformity with the Behavioral Wellness Mental Health Plan, available at [County of Santa Barbara Behavioral Wellness Policies and Procedures](#).

C. Discharge Plan. The CFT Treatment Team shall work closely with each member and with Program staff to establish a written discharge plan that is responsive to the member's needs and personal goals.

12. **NON-REIMBURSEMENT.**

A. IHBS. Contractor understands and agrees that Contractor's failure to obtain the Department of Behavioral Wellness QCM authorization or reauthorization for IHBS prior to the provision of IHBS services, or Contractor's provision of IHBS services outside of the scope of the Department of Behavioral Wellness QCM authorization or reauthorization for IHBS shall result in non-reimbursement.

B. TBS. TBS services are not reimbursable under the following conditions:

- 1. For the convenience of the member's family/caregivers, physician, or teacher;

2. To provide supervision or to assure compliance with terms and conditions of probation;
3. To ensure the member's physical safety or the safety of others (e.g. suicide watch);
4. To address conditions that are not a part of the member's mental health condition;
5. For members who can sustain non-impulsive, self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transactions during the day; or
6. For members who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision; or when the member is an inpatient of a hospital, psychiatric health facility, nursing facility, Institute for Mental Disease (IMD), or crisis residential facility.

13. REPORTING AND MONITORING. (Reserved)

14. STAFFING REQUIREMENTS. Contractor shall staff the Program with provider types and qualifications in compliance with California State Plan Amendment 23-006, BHIN 24-023, and the concomitant amendments to titles 9 and 22 of the California Code of Regulations, Contractor may utilize provider types for the delivery of services under this Program as set forth in the applicable Specialty Mental Health Service Table at [MedCCC - Library](#).

A. Staff-to-Member Caseload Ratio. The target program staff-to-member ratio that does not exceed one to seven (1 Full-Time Equivalent [FTE] Staff member per 7 members). The target Lead TBS Program staff-to-member ratio shall include a maximum of one staff to four members. The target TBS Clinical Coordinator staff-to-member ratio shall include a maximum of one to three members.

B. Program staffing is anticipated to include up to 18.08 FTE as follows:

1. 2.0 FTE Clinical Supervisors. The responsibilities of the Clinical Supervisors shall include but not be limited to clinical oversight of treatment teams; development of Member Service Plans; review and approval of all case documentation; clinical training of staff; consultation regarding member case; and individual supervision;
2. 2.0 FTE Program Lead;
3. 1.0 FTE TBS Clinical Coordinator;

4. 10.0 FTE TBS Specialists. Responsibilities of TBS Specialists shall include but not be limited to individual Targeted Case Management; implementation and execution of the member's Member Service Plan; one-to-one member interventions; daily reporting of developments regarding the member's case; and providing consultation to and coaching parties on behavior management;
5. 1.0 FTE Program Manager. Responsibilities of the Program Manager shall include but not be limited to budget development, staff management, ensuring compliance with applicable regulations and ensuring Program fidelity;
6. 1.33 FTE Administrative Support staff;
7. 0.35 FTE Regional Director Community Based Service; and
8. 0.40 FTE Assistant Director Community Based Service.

15. GOALS, OUTCOMES, AND MEASURES.

A. Contractor shall comply with the program goals, outcomes and measures in Subsection B of this Section (Goals, Outcomes, and Measure) and comply with modification to the program goals, outcomes, and measures that do not alter the maximum contract amount of this Agreement and are authorized by the Director of the Department of Behavioral Wellness or designee in writing pursuant to Section 25 (Entire Agreement and Amendment) of the Standard Terms and Conditions of this Agreement.

B. Contractor shall meet the following outcomes and measures as identified below:

Program Evaluation			
Program Goals	Outcomes	Measures	
		IHBS/ICC	TBS
1. Census Information	Unique Members Served during quarter	#	#
	Enrollments	#	#
	New enrollment during quarter	#	#
	Discharges	#	#
	1. Incarcerations/Juvenile Hall	≤10%	≤5%

2. Symptom Acuity. Reduce mental health and substance abuse symptoms resulting in reduced utilization of involuntary care.	2. Total discharges from incarceration in the quarter	#	#
	3. Of those with an incarceration: Follow up after discharge from jail/juvenile hall within 7 days	≥95%	≥95%
	4. Psychiatric inpatient admissions	≤10%	≤5%
	5. Total discharges from inpatient admissions in the quarter	#	#
	6. Of those with an inpatient admission: Follow up after discharge from inpatient hospital within 7 days	≥95%	≥95%
	7. Crisis Services	≤10%	≤10%
	8. IP-CANS/ANSA (% completed)	≥95%	N/A
	9. IP-CANS Improvement by 10% or more in 3+ Domains (Out of 6 total domain)	≥50% (In 3 of 6)	N/A
	10. PSC (% completed)	≥95%	N/A
3. Stabilization in Community. Assist members in their mental health recovery process and with developing the skills necessary to lead independent, healthy, and productive lives in the community.	1. Successful discharge	>85%	>85%
	2. Members discharged against members choice (involuntary discharge)	<5%	N/A

**EXHIBIT A-3 (RESERVED) MHS
STATEMENT OF WORK:
DAY REHABILITATION/DAY TREATMENT INTENSIVE**

(RESERVED)

**EXHIBIT A-4 MHS
STATEMENT OF WORK:
SENATE BILL (SB) 163/WRAPAROUND SERVICES**

- 1. PROGRAM SUMMARY.** Contractor shall provide intensive mental health services to children and youth (0-21 years of age) members (defined in Section 6 [Members] of this Exhibit) (hereafter, Program) who would otherwise be placed in a Short-Term Residential Therapeutic Program (STRTP), as an alternative to group home care using expanded family-based services. Contractor shall comply with all applicable requirements set forth in Exhibit AA General Provisions: ADP/MHS of this Agreement.
- 2. PROGRAM OBJECTIVES.** The objectives of the Program are to:
 - A.** Maintain the member in their homes and communities whenever possible;
 - B.** Support the member's ability to adapt and cope with changing life circumstances;
 - C.** Define and refine member's family strengths, culture, vision and needs;
 - D.** Prioritize member's family needs to create a plan that will help meet those needs; and
 - E.** Carry out the Member Service Plan one need at a time until the member no longer requires Program supports because the member's family's vision has been achieved.
- 3. SERVICES.**
 - A.** The Program shall include the following services as described in Section II Program Service Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement and in accordance with Senate Bill (SB) 163 (Wraparound Services) as defined in California Welfare and Institutions Code (WIC) Sections 18250 et seq. available at [Welfare and Institutions Code Section 18250](#):
 - 1.** Assessment/Reassessment;
 - 2.** Collateral;
 - 3.** Crisis Intervention;
 - 4.** Intensive Home Based Services (IHBS);
 - 5.** Plan Development;
 - 6.** Rehabilitation;

7. Targeted Case Management; and

8. Therapy.

B. Service Intensity. Contractor shall provide wraparound services to members in the amount, scope, and duration authorized by the Interagency Placement Committee (IPC) (See Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit).

4. ADDITIONAL SERVICE REQUIREMENTS. Contractor shall provide additional services that do not alter the maximum contract amount of this Agreement and are authorized by the Director of the Department of Behavioral Wellness or designee in writing in accordance with Section 25 (Entire Agreement and Amendment) of the Standard Terms and Conditions of this Agreement.

A. The Program operates on a community-based wraparound model, utilizing a "whatever it takes" approach to identify and integrate thoughtful, responsive and creative interventions for members and their families.

B. Contractor has executed a contract with the County, administered by the Department of Social Services (DSS) for reimbursement of the Program's operational expenses that are not Medi-Cal eligible. Collaboration between County and Contractor allows the Program to provide a full-service partnership for members, where members receive a full spectrum of services in order to achieve the goals identified in their individualized Member Service Plan.

5. OPERATIONS.

A. Licensure/Certification. DHCS Specialty Mental Health Services Medi-Cal Licensure and certification is required.

B. Location. The Program shall be located at the following location(s):

1. 2605 S. Miller St, Suite 101, Santa Maria, California; and

2. 120 Cremona, Suite 220, Goleta, CA 93117.

C. Treatment Location. Services shall be delivered in person in the home or in appropriate settings in the community.

D. Hours of Operation and Staff Coverage. Program staff shall be available 24 hours per day, 7 days per week, and 365 days per year.

E. Capacity. The target census for services described in Section 3 (Services) is 16 members.

F. Policies and Procedure. Contractor shall develop and maintain written policies and procedures prior to delivering services to members to set expectations for Program staff and establish consistency of effort. The written policies and procedures shall be consistent with all applicable state and federal standards and shall address the following:

1. Informed consent for treatment, including medication;
2. Member rights, including the right to treatment with respect and dignity, under the least restrictive conditions, delivered promptly and adequately;
3. Process for member filings of grievances and complaints;
4. Management of member funds, as applicable, including protections and safeguards to maximize members' control of their own money;
5. Admission and discharge (e.g. admission criteria and process; discharge criteria, process and documentation);
6. Personnel (e.g. required staff, staffing ratios, qualifications, orientation and training);
7. Hours of operation and coverage, service intensity, staff communication and planning emphasizing a team approach, and staff supervision;
8. Assessment and treatment processes and documentation (e.g. comprehensive assessment, treatment planning, progress notes);
9. Treatment, rehabilitation and support services;
10. Member medical record maintenance;
11. Program evaluation and performance (quality assurance); and
12. Procedures for compliance with applicable State and Federal laws, including all Equal Employment Opportunity (EEO)/Affirmative Action (AA) requirements. Contractors shall comply with the Americans with Disabilities Act.

G. Communications. Contractor shall participate as a representative on the Wraparound Implementation Team (WIT) Core Group, a subcommittee of the Interagency Placement Committee (IPC). The WIT Core Group shall meet weekly, or as otherwise determined by the group. Contractor shall also participate in Quarterly WIT Leadership Meetings where contract, program, and compliance issues (among others) are considered from an upper management perspective.

6. MEMBERS.

- A. Contractor shall provide Wraparound services to children and youth (0 to 21 years of age) who meet Medi-Cal eligibility and residency, or county of responsibility requirements, and are either at risk of, or returning from high level out-of-county residential placement, and their families.
- B. Program admission requirements are more fully described in Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit. (Collectively, members).
- C. Contractor's provision of services to members under this Program shall not exceed the funding levels projected in Exhibit B-1 MHS.

7. REFERRALS.

- A. **Referral Sources.** Clients are referred for consideration by DSS/CSW, or Santa Barbara County Probation.
- B. **Referral Documentation.** Contractor shall work directly with the referral source to obtain referral documentation required by Contractor to screen referred children and youth for Program services eligibility.
 - 1. The IPC WIT Core Group shall make the determination if a member is accepted into the Program.
 - 2. The referring agency shall complete an SB 163 Referral Form for each member and shall present the member's case at the IPC WIT Core Group meetings for review and approval by quorum voting of core members.
- C. **Referral Packet.** Contractor shall receive a referral packet for each member referred and treated. Any items provided in hard copy that are available in the Behavioral Wellness Medical Record system shall be shredded by Contractor upon opening the members to the program. The referral packet shall include:
 - 1. A copy of the Behavioral Wellness referral form;
 - 2. A member's face sheet listing all of the programs that the member has been admitted to over time, and is currently admitted to, including hospitalizations;
 - 3. A copy of the most recent comprehensive assessment or assessment update;
 - 4. A copy of the most recent medication record and health questionnaire;

5. A copy of the currently valid Behavioral Wellness Members Service Plan (CSP) indicating the goals for members enrollment in the Program and which names Contractor as service provider;
6. Members' Medi-Cal Eligibility Database Sheet (MEDS) file printout, as provided to Contractor in the initial Referral Packet. Thereafter, it will be Contractor's responsibility to verify continued Medi-Cal eligibility; and
7. Other documents as reasonably requested by County.

8. AUTHORIZATION, INTAKE, ADMISSION AND REAUTHORIZATION.

- A. Medi-Cal Eligibility and Residency or County of Responsibility.** Contractor shall verify each referred child or youth's Medi-Cal eligibility and Santa Barbara County residency as described in Section IV Administrative Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement.
- B. Timely Access to Services.** In accordance with 42 Code of Federal Regulations (C.F.R.) section 438.206, Contractor shall meet standards for timely access to care and services, taking into consideration the urgency of need for services. Contractor shall attempt to provide first service for routine referrals within 10 business days and within 48 hours for referrals determined to be urgent as outlined in *Department Policy # 2.001 Network Adequacy Standards and Monitoring*.
- C. Submit Authorization Request to QCM.** (RESERVED)
- D. Admit Members Meeting Medical Necessity.** Contractor shall admit members referred by the Department of Social Services (DSS)/Child Welfare Services (CWS), or County of Santa Barbara Probation, who meet medical necessity, unless the member meets one or more conditions specified in Section 9 (Exclusion Criteria), or if space is not available in the Program.
- E. Notification to Behavioral Wellness Access Line/Quality Care Management.**
 - 1. If Member Not Accepted into Program.** Referral to appropriate level of care will be determined by Contractor and BWell during the IPC meeting to identify appropriate resources to meet members' needs.
 - 2. If Member Needs Another Level of Care.** Contractor shall document in the assessment the actual level of care placement. Any variance in placement shall be documented in the assessment and will include the reasons for the difference in level of care.

3. If Space Not Available in Program. (RESERVED)

F. Submit Reassessment to QCM. (RESERVED)

9. EXCLUSION CRITERIA.

- A.** On a case-by-case basis, children or youth referred for admission into the Program or members admitted into the Program may be excluded from the Program. The following may be cause for exclusion from the Program:
- 1.** Threatening or violence towards staff or other members;
 - 2.** Rude or disruptive behavior that cannot be redirected; and
 - 3.** Not meeting medical necessity criteria in accordance with Section 6 Members and Section 8 Authorization, Admissions, Intake and Reauthorization of this Agreement.
- B.** Contractor shall notify the child or youth referred for admission into the Program or members admitted into the Program of the exclusion from the Program in compliance with *Department Policy #4.010 Notice of Adverse Benefit Determination*.

10. DOCUMENTATION REQUIREMENTS.

- A. Data Entry and Clinical Documents.** Contractor shall enter treatment data, other member data, and clinical documentation required by County into Department of Behavioral Wellness Electronic Health Record unless otherwise approve.
- B. Documentation Requirements.** Contractor must comply with all documentation requirements in accordance with title 22 C.C.R. section 51303 and Welfare and Institutions Code sections 14184.402, subd. (a) and 14059.5 and BHINs 21-071, 23-001, and 23-068; the Integrated Intergovernmental Agreement as described in Section I Performance Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement; and Department Policy #8.102 CalAIM Documentation Reform.
- C. Member Service Plan.** The Behavioral Wellness Treatment Team in collaboration with Contractor shall complete a Member Service Plan for members who have a case file (episode) open to the Behavioral Wellness Children's clinic in accordance with the Behavioral Wellness Clinical Documentation Manual available at [County of Santa Barbara Behavioral Wellness](#).

1. Upon approval of the Assessment, the Contractor shall complete a Behavioral Wellness Treatment Plan for each member receiving services. All Member Service Plans must be completed within 60 days of referral.
2. For members referred to the Program that are open to Behavioral Wellness, the Behavioral Wellness Treatment Team shall complete a Behavioral Wellness Member Service Plan in collaboration with Contractor for each member receiving Program services within 10 days of referral. The Behavioral Wellness Member Service Plan shall provide overall direction for the collaborative work of the client, the Program and the Behavioral Wellness Treatment Team, as applicable.

D. SB163 Plan of Care (POC), the Client Treatment Plan. The SB163 Plan of Care. (POC) shall be completed by the Contractor with input from Behavioral Wellness and the approval of IPC WIT. The POC shall include individualized strengths and needs of the family including identified goals that are informed by the Behavioral Wellness Member Service Plan to guide interventions to meet those needs.

11. DISCHARGE.

- A. Discharge Planning Required.** The members' discharge and transition plan shall be completed by the Child and Family Team, which is comprised of Contractor's staff, client and family, referring agency, Behavioral Wellness Treatment Team, and other resource partners, as needed.
- B. Discharge Plan.** The members' discharge plan shall be responsive to the client's needs and personal goals.
- C. Discharge Criteria.** The appropriateness for member discharge shall be determined on a case-by-case basis by the IPC WIT Core Group. Contractor shall follow Behavioral Wellness' policy and procedures regarding discharges in conformity with Behavioral Wellness' role as the Mental Health Plan. Criteria for discharge include:
 1. Treatment goals have been sufficiently met;
 2. The determination that the treatment goals have not been met as determined by the Child and Family Team with input from Behavioral Wellness. The member and family shall be provided with referrals to more appropriate treatment.

3. The determination that significant progress has been made, even if not all goals have been met, such that the member and family no longer require the intensive level of services provided by the Program;
4. The member's request to terminate services;
5. Member and family relocating outside of the Program's service area; or
6. Member's case is closed to Probation or DSS/CWS making them ineligible to receive SB 163 Services.

12. NON-REIMBURSEMENT. (RESERVED)

13. REPORTING AND MONITORING. (RESERVED)

- 14. STAFFING.** Contractor shall staff the Program with provider types and qualifications in compliance with California State Plan Amendment 23-006, BHIN 24-023, and the concomitant amendments to titles 9 and 22 of the California Code of Regulations. Contractor may utilize provider types for the delivery of services under this Program as set forth in the applicable Specialty Mental Health Service Table at [MedCCC - Library](#).

A. Staff-to Member Caseload Ratios.

1. The target Family Facilitator staff-to-member ratio includes one to six [one FTE direct service staff member per six members];
2. The target Parent Partners staff-to-member ratio includes one to 10 [one FTE staff member per 10 members];
3. The target Child and Family Specialists (CFS) staff-to-member ratio includes one to five [one FTE staff member per five members].

B. Program staffing is anticipated to include up to 5.025 Full Time Equivalent (FTE), who shall be licensed mental health professionals or waived/registered professionals, as follows:

1. 1.0 FTE Child and Family Specialist;
2. 0.50 FTE Clinical Supervisor;
3. 0.35 FTE Program Manager;
4. 0.5 FTE Family Facilitator;
5. 0.50 FTE Lead Child and Family Specialist;

- 6. 0.50 FTE Lead Wraparound Program Liaison;
- 7. 0.50 FTE Lead Family Facilitator;
- 8. 0.50 FTE Parent Partner;
- 9. 0.425 FTE Administrative Assistant I/II;
- 10. 0.125 FTE Regional Director of Community Services;
- 11. 0.125 FTE Assistant Director of Community Services.

15. PROGRAM GOALS, OUTCOMES AND MEASURES.

- A.** Contractor shall comply with the program goals, outcomes, and measures in Subsection B of this Section (Goals, Outcomes, and Measures). Contractor shall comply with changes to the program goals, outcomes, and measures that do not alter the maximum contract amount of this Agreement and are authorized by the Director of the Department of Behavioral Wellness or designee in writing pursuant to Section 25 (Entire Agreement and Amendment) of the Standard Terms and Conditions of this Agreement.
- B.** Contractor shall meet the SB 163/Wraparound program goals and outcomes and measures as identified below:

Wraparound Program Evaluation		
Program Goals	Outcomes	Goal
Census Information	1. Unique Clients Served	#
	2. Enrollments	#
	3. New Enrollments	#
	4. Discharges	#
Symptom Acuity. Reduce mental health and substance abuse symptoms resulting in reduced utilization of involuntary care.	1. % Unique Clients with Incarceration	≤5
	2. Of those with an incarceration: Follow up after discharge from jail/juvenile hall within 7 days	≥95
	3. % Unique clients with Psychiatric Inpatient Hospitalization	≤5
	4. Of those with an inpatient hospitalization: Follow up after discharge from inpatient hospital within 7 days	≥95
	5. % Unique Clients with Crisis Intervention	≤10

	6. IP-CANS/ANSA/PSC Completion (% completed)	≥95
	7. IP-CANS Improvement in 3+ Domains (% domains with > 10% improvement)	≥50
	8. ANSA Improvement	TBD
	9. PSC Improvement	TBD
Stabilization in Community. Assist clients in their mental health recovery process and with developing the skills necessary to lead healthy and productive lives in the community.	1. Stable/permanent housing	≥95
	2. % Successful Discharges	≥85
	3. % Involuntary Discharges	≤5

**EXHIBIT A-5 MHS
STATEMENT OF WORK:
FAMILY URGENT RESPONSE SYSTEM (FURS)**

- 1. PROGRAM SUMMARY.** Contractor shall provide 24 hours per day, 7 days per week, 365 days per year (24/7/365) state-level phone-based response and county-level in-home, in-person mobile response, triage services, follow-up support, and information and referral services to current and former foster children and youth, (up to 21 years of age) and non-minor dependent members (NMD) (defined in Section 6 [Members] of this Exhibit) (hereafter, Program) and their caregivers.

This Agreement between Contractor and County, administered by the Department of Behavioral Wellness, provides reimbursement for Program specialty mental health services provided to County foster youth. In addition, Contractor has executed a contract with the County, administered by the Department of Social Services (DSS), for reimbursement of the Program's operational expenses that are not Medi-Cal eligible.

Contractor shall comply with all applicable requirements set forth in Exhibit AA General Provisions: ADP/MHS of this Agreement.

- 2. PROGRAM OBJECTIVES.** The objectives of this Program are:
- A.** Prevent, reduce, and decrease placement disruptions to preserve the foster youth-caregiver relationship and promote long-term stability for youth;
 - B.** Offer immediate, trauma informed support for current and former foster youth and caregivers, providing a safe alternative to 911 calls, law enforcement involvement, and the criminalization of traumatized youth;
 - C.** Prevent psychiatric hospitalizations, congregate care, and out-of-home placement facilities; and
 - D.** Promote healing as a family unit, develop health conflict resolution and relationship skills, and improve the retention of current foster caregivers.
- 3. SERVICES.** The Program shall include the following services as described in Section II Program Service Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement:
- A.** If the foster youth is a Medi-Cal beneficiary who meets medical necessity criteria for Specialty Mental Health Services and is an active and open admissions in Clinician Gateway, Contractor shall provide any or all of the following services by credentialed staff if all Medi-Cal requirements are met. For members who are not a Medi-Cal beneficiary, do not meet medical necessity criteria for Specialty

Mental Health Services and are not an active and open admissions in Clinician Gateway, the Contractor shall provide only Crisis Intervention services:

1. Collateral;
2. Crisis Intervention;
3. Intensive Case Management (ICC);
4. Rehabilitation; and
5. Targeted Case Management;

4. **ADDITIONAL SERVICE REQUIREMENTS.** Contractor shall provide 24/7/365 phone response for calls coming in from the state FURS hotline to include but not limited to the following:

A. In person response whenever requested by the caller. Calls will be determined either “urgent” or “routine” based on the callers’ request for timely response.

1. Urgent calls must be responded to within 1 hour, but not to exceed 3 hours in extenuating circumstances.
2. Routine calls will be responded to within 24 hours.

B. Whether by phone or in person, services will include the following trauma informed, culturally and linguistically responsive interventions as well as the 72 hour follow up phone call:

1. Brief mental health and substance use disorder screening;
2. Strength based risk assessment;
3. Crisis intervention;
4. De-escalation and stabilization of the situation;
5. Safety planning;
6. Mediation;
7. Coaching;
8. Stress Reduction;
9. Information and referrals; and
10. Linkages to needed services and resources.

- C.** Utilize individuals with specialized training in trauma of children or youth and the foster care system on the FURS Response Team. Efforts should be made to include peer partners and those with lived experience in the FURS Response Team and to provide follow-up efforts whenever possible;
- D.** Utilize the information provided by the State FURS hotline staff during the warm handoff to determine if and when a FURS Response Team will be sent to the family's home based on the urgency;
- E.** Develop a plan to identify if the foster youth has an existing child and family team so that efforts can be coordinated to address the instability;
- F.** Be responsible for making referrals to appropriate needed services as part of the Phone Line requirement;
- G.** Provide the family with a plan of action to address identified additional support or ongoing stabilization needs and connect them to needed ongoing services through the existing local system of care;
- H.** Provide in-home de-escalation, stabilization, and support services and supports, including all of the following:
 - 1.** Establish in-person, face-to-face contact with the foster youth and caregiver.
 - 2.** Identify the underlying causes of, and precursors to, the situation that led to the instability.
 - 3.** Identify the caregiver interventions attempted and observe the foster youth and caregiver interaction.
 - 4.** Diffuse the immediate situation.
 - 5.** Coach and work with the caregiver and foster youth in order:
 - i.** to preserve the family unit and maintain the current living situation; or
 - ii.** create a temporary alternative plan if necessary.
 - 6.** Establish connections to other county- or community-based supports and services to ensure continuity of care, including, but not limited to, linkage to additional trauma-informed and culturally and linguistically responsive family supportive services and foster youth and family wellness resources.
 - 7.** After the initial face-to-face response, follow-up over the next 72 hours to determine if additional supports or services are needed.

8. Identify any additional support or ongoing stabilization needs for the family and developing a plan for, or referral to, appropriate youth and family supportive services within the county.

- I. Contractor will develop a process for communication with Child Welfare Services, Probation Department and the Department of Behavioral Wellness within 24 business hours for any calls received/services provided to any foster youth receiving services from these agencies.

J. County Responsibility.

1. County shall provide administrative oversight of the FURS Program.
2. A designated Behavioral Wellness liaison will be available to provide updates on the FURS system and participate in FURS monthly or quarterly meetings, as scheduled.

5. OPERATIONS.

- A. Licensure/Certification.** DHCS Specialty Mental Health Services Medi-Cal Licensure and certification is required.

- B. Location.** The Program shall be located at the following location(s):

1. 2605 S. Miller St., Suite 101, Santa Maria, California;
2. 120 Cremona Drive, Suite 220, Goleta, California

- C. Treatment Location.** Program services shall be provided in the community or via telephone.

- D. Hours of Operation and Staff Coverage.** Program staff shall be available 24 hours per day, 7 days per week, and 365 days per year.

- E.** Contractor's operations shall include, but not be limited to, the following:

1. Operate a 24/7/365 phone line to receive incoming, State referred calls, and provide a warm handoff to callers (Phone Line) from the State of California FURS hotline.
 - i. Contractor shall establish a dedicated and published phone number, answering services cannot be used. Contractor must include protocols for obtaining interpreter services for limited English proficient and Deaf and Hard of Hearing callers to the Phone Line.

- ii. Maintain FURS Mobile Response and Stabilization Teams (FURS Response Team) consisting of FURS Specialist, FURS Parent Partners and Wraparound Program manager, who shall provide in-person responses, and shall be deployed to provide mobile in-person/face-to-face trauma informed and culturally responsive crisis intervention, mediation, and support for foster youth and/or their foster parents/caregivers who are experiencing crisis, or emotional, physical, or behavioral distress that, without immediate support, risks disruption to the current living situation.
- iii. The Phone Line and FURS Response Teams shall not include law enforcement.
- iv. In-person and over the phone follow up services within 72 hours after the initial face-to-face response to if additional services or supports are needed.

6. MEMBERS.

- A. Contractor shall provide FURS program services to current and former foster youth (up to age 21), nonminor dependents (NMD), and justice involved youth who meet Medi-Cal eligibility and residency or county of responsibility requirements, and are experiencing crisis, or emotional, physical, or behavioral distress that, without immediate support, risks disruption to the current living situation. Program services are also available to members' caregivers.
- B. Program admission requirements are more fully described in Section 8 (Authorization, Admission, Intake, and Reauthorization) of this Exhibit. (Collectively, members.)
- C. Contractor shall admit members with co-occurring disorders, pregnant and postpartum women as appropriate.
- D. Contractor's provision of services to members under this Program shall not exceed the funding levels projected in Exhibit B-1 MHS.

7. REFERRALS.

A. Referral Sources and Procedure.

- 1. **Referral Source.** Members served will be referred directly to Contractor through the State operated FURS Hotline.
- 2. **Referral Procedure.** Members will be screened and triaged by a statewide hotline..

B. Referral Documentation. Contractor shall open all County clients in the County Share Care system.

8. AUTHORIZATION, INTAKE, ADMISSION AND REAUTHORIZATION.

A. Medi-Cal Eligibility and Residency or County of Responsibility. Contractor shall verify each referred child or youth's Medi-Cal eligibility and Santa Barbara County residency as described in Section IV Administrative Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement.

B. Admit Members Meeting Medical Necessity. Contractor shall admit members referred by the Department, who meet medical necessity, unless the member meets one or more conditions specified in Section 9 (Exclusion Criteria), or if space is not available in the Program.

C. Once screened and triaged by a statewide hotline as deemed clinically appropriate, local FURS Response Team staff will be deployed in the time frame established based on the urgency of the call to provide mobile in-person/face-to-face trauma informed and culturally responsive crisis intervention, mediation, and support for foster youth and/or their foster parents/caregivers.

9. EXCLUSION CRITERIA.

A. On a case-by-case basis, individuals referred for admission into the Program or members admitted into the Program may be excluded from the Program. The following may be cause for exclusion from the Program:

1. Threatening or violence toward staff or other members;
2. Rude or disruptive behavior that cannot be redirected; or
3. Not meeting medical necessity criteria in accordance with title 22 C.C.R. section 51000 et seq.; Welfare and Institutions Code sections 14184.402, subdivision (a) and 14059.5; and BHINs 21-071, and 23-001.

10. DOCUMENTATION REQUIREMENTS.

A. Data Entry and Clinical Documents. Contractor shall enter treatment data, other member data, and clinical documentation required by County into Department of Behavioral Wellness Electronic Health Record unless otherwise approve.

B. Documentation Requirements. Contractor must comply with all documentation requirements in accordance with title 22 C.C.R. section 51303 and Welfare and Institutions Code sections 14184.402, subd. (a) and 14059.5 and BHINs 21-071,

23-001, and 23-068; the Integrated Intergovernmental Agreement as described in Section I Performance Requirements of Exhibit AA General Provisions: ADP/MHS of this Agreement; and Department Policy #8.102 CalAIM Documentation Reform.

- 11. DISCHARGE.** (RESERVED)
- 12. NON-REIMBURSEMENT.** (RESERVED).
- 13. REPORTING AND MONITORING.** Reports shall include, but are not limited to, the following:
 - A.** A monthly project activity report that details participation statistics of activities as required.
 - B.** The report will include a list of calls received from the State FURS Hotline with the following information:
 1. The date and time of call and issue;
 2. Name of foster youth involved;
 3. Type of response (i.e.: in person, phone, etc.);
 4. Referral to other agency(ies) if any;
 5. Outcome and follow up findings; and
 6. Any other pertinent notes that will help the Department Social Services Worker (SSW) to prevent, reduce, decrease placement disruptions and preserve the relationship between the foster youth and their caregiver.
 - C.** Reports shall be sent electronically in an Excel format as provided by Behavioral Wellness by the fifteenth (15th) calendar day of each month following the month in which services were rendered.
 - D.** Contractor shall be subject to State or County monitoring activities necessary to assure compliance with regulations and contractual requirements.
- 14. STAFFING.** Contractor shall staff the Program with provider types and qualifications in compliance with California State Plan Amendment 23-006, BHIN 24-023, and the concomitant amendments to titles 9 and 22 of the California Code of Regulations. Contractor may utilize provider types for the delivery of services under this Program as set forth in the applicable Specialty Mental Health Service Table at [MedCCC - Library](#).

A. Additional Staffing Requirements.

- 1. Criminal Records Check.** Contractor shall ensure that all prospective and existing staff performing services as part of, related to, or in connection with this agreement shall have a criminal record check, and Contractor shall pay for any and all associated costs. The criminal record check shall consist of a California Department of Motor Vehicle check, and a Live Scan submitted to the California Department of Justice.
- 2. Required Staff Records Check Form and Criminal Law Violation Notification.**
 - i. Contractor shall complete and submit the Staff Records Check form as appropriate for existing and prospective staff.
 - ii. Prospective Contractor staff may commence services only after the results of the Live Scan have been reported to County and County deems the person suitable for work pursuant to this Agreement. Failure by Contractor to comply with the criminal record check requirements may result in withholding of invoice payments until compliant.
 - iii. Contractor shall provide written notice, within twenty-four (24) hours of Contractor's knowledge of any new criminal law violation by staff.
- 3.** Staffing costs will be allocated to Behavioral Wellness/County based on direct services hours spent on specialty mental health services.

15. PROGRAM GOALS, OUTCOMES AND MEASURES.

- A.** Contractor shall comply with the program goals, outcomes, and measures in Subsection B of this Section (Goals, Outcomes, and Measures). Contractor shall comply with changes to the program goals, outcomes, and measures that do not alter the maximum contract amount of this Agreement and are authorized by the Director of the Department of Behavioral Wellness or designee in writing pursuant to Section 25 (Entire Agreement and Amendment) of the Standard Terms and Conditions of this Agreement.
- B.** Contractor shall meet the Family Urgent Response System (FURS) program goals, outcomes and measures as identified below:

FURS Program Evaluation		
Program Goals	Outcomes	Goal
Census Information	1. Total Number of Calls	#

	2. Total Number of Foster Youth	#
	3. Total Number of Participants Surveyed	#
Respond to Calls Timely and Effectively to De-Escalate Potential Crises	1. % of calls responded to within 1 hour	≥95%
	2. % calls de-escalated without need for law enforcement or hospitalization	≥90%
Maintain youth stability in the community	1. % Foster Youth maintained community placement at 72-hour follow up	≥90%
	2. % participants surveyed who express satisfaction with the FURS response	≥90%

EXHIBIT AA

ADP AND MHS

GENERAL PROVISIONS

**EXHIBIT AA ADP/MHS
GENERAL PROVISIONS**

The following provisions shall apply to all Alcohol and Drug Program and Mental Health Services programs operated under this Agreement for the provision of Drug Medi-Cal Organized Delivery System (DMC-ODS) and specialty mental health services (SMHS) to Medi-Cal members residing in Santa Barbara County or county of responsibility who meet the applicable access criteria, included as Exhibit(s) A-1 through A-5, unless separately and specially set forth in the this General Provision or scope of work specific to each program.

County of Responsibility is defined as “the county of responsibility shall be the county whose county department is responsible for determining the initial and continuing Medi-Cal eligibility for a person or family. The appropriate county of responsibility shall be determined in accordance with the California Code Title 22 section 50120.”

SECTION I. PERFORMANCE REQUIREMENTS
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1. PERFORMANCE.

A. This Agreement shall be governed by and construed in accordance with all laws and regulations and all contractual obligations of County under the Integrated Intergovernmental Agreement (Contract No. 24-40145) (hereafter referred to “Integrated Intergovernmental Agreement”) between County and the California Department of Health Care Services (DHCS) including the federal and state requirements listed in Integrated Intergovernmental Agreement, Exhibit E (Additional Provisions), section 7 (State and Federal Laws Governing this Contract) and contractual obligations in Integrated Intergovernmental Agreement, Exhibit D (Special Terms and Conditions). The Integrated Intergovernmental Agreement, available at [County of Santa Barbara - File #: 25-00016](#), is incorporated herein by reference.

- 1.** Contractor agrees to comply with the Special Terms and Conditions (STCs) of the DMC-ODS waiver, and by the Intergovernmental Agreement between the County Department of Behavioral Wellness (Department) and State Department of Healthcare Services (DHCS) for providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for Substance Use Disorder treatment, of the Intergovernmental Agreement.
- 2.** Contractor agrees to comply with all applicable federal, state, and local laws including federal and state laws pertaining to member rights, applicable

sections of California's Medicaid State Plan (State Plan), applicable federal waivers, and applicable DHCS Behavioral Health Information Notices (BHIN(s)) in its provision of services as a subcontractor or contracted provider of County as an integrated county behavioral health plan.

3. Contractor agrees to perform all applicable delegated activities and obligations including services and reporting responsibilities in compliance with County's obligations under the Integrated Intergovernmental Agreement.
4. Contractor agrees to comply with any changes to these statutes and regulations, State Plan, federal waivers, or BHINs or any amendments to the Integrated Intergovernmental Agreement that occur during the Term of this Agreement. Contractor shall also comply with any newly applicable statute, regulation, State Plan Amendment, federal waiver, and BHIN that become effective during the Term of this Agreement. These obligations shall apply without the need for an amendment(s) of this Agreement. If the parties amend the affected provisions of this Agreement to conform to the changes in law or the Integrated Intergovernmental Agreement, the amendment shall be retroactive to the effective date of such changes in law or the Integrated Intergovernmental Agreement.
5. To the extent there is a conflict between a provision of this Agreement and any federal, state, or local statute or regulation, State Plan, federal waiver, or BHIN or provision of the Integrated Intergovernmental Agreement, Contractor shall comply with the federal, state, or local statute or regulation, State Plan, federal waiver, or BHIN or provision of the Integrated Intergovernmental Agreement, and the conflicting provision of this Agreement shall no longer be in effect.
6. Contractors shall comply with:
 - i. All applicable Behavioral Health Services Act laws, regulations, BHINs, policy letters, and guidance; and
 - ii. The Santa Barbara County Mental Health Services Act Steering Committee Mission Statement, available at [Mental Health Services Act Steering Committee Santa Barbara County, CA - Official Website](#)

B. Contractor shall comply with the following as applicable:

1. All Medicaid laws, regulations including sub-regulatory guidance, and contract provisions;
2. 42 Code of Federal Regulations (C.F.R.) part 438 as applicable;

3. 42 C.F.R. section 438.900 et seq. regarding parity in mental health and substance use disorder benefits;
4. 42 Code of Federal Regulations (C.F.R.) part 2, regarding confidentiality of substance use disorders patient records;
5. All laws and regulations relating to patients' rights including Welfare and Institutions Code (Welf. & Inst. Code) section 5325, 9 California Code of Regulations (Cal. Code Regs.) sections 862 through 868, and 42 Code of Federal Regulations section 438.100; and
6. All existing policy letters issued by DHCS. All policy letters issued by DHCS subsequent to the effective date of this Agreement shall provide clarification of Contractor's obligations pursuant to this Agreement.

C. Alcohol and Drug Programs. (RESERVED).

D. Mental Health Program. This Contract is entered into in accordance with Welfare and Institutions Welfare & Institutions Code (hereafter W&I Code) sections 14680 -14727, and 14184.100 et seq. W&I Code section 14712 requires DHCS to implement managed mental health care for Medi-Cal members through contracts with mental health plans.

E. Substance Use Block Grant Requirements. (RESERVED)

F. Suspension For Convenience. The Director of the Department of Behavioral Wellness or designee may, without cause, order Contractor in writing to suspend, delay, or interrupt the services under this Agreement in whole or in part for up to 120 days. County shall incur no liability for suspension under this provision and suspension shall not constitute a breach of this Agreement.

SECTION II. PROGRAM SERVICE REQUIREMENTS

1. SERVICES.

A. Alcohol and Drug Program Services. (RESERVED)

B. Mental Health Services. Contractor shall develop, support, and empower family units by identifying existing strengths and areas of need, and teaching problem solving skills. Contractor may provide the following services, as identified in the applicable Statement of Work to Program members:

1. **Assessment/Reassessment.** "Assessment" means a service activity designed to collect information and evaluate the current status of a member's

mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that member. Assessments shall be conducted and documented in accordance with applicable state and federal statutes, regulations, and standards. (State Plan, Supplement 3 to Attachment 3.1-A, page 1 [TN 22-0023].)

- i. Child and Adolescent Needs & Strengths and Adult Needs and Strengths Assessment. The Child and Adolescent Needs and Strengths (IP-CANS) is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. The Adult Needs and Strength Assessment (ANSA) is a multi-purpose tool developed for adult's mental health services to support care planning.
 - a. Contractor shall complete the IP-CANS for each member age zero and up to 20 years, and the ANSA for each member age 21 years or older.
 - b. The IP-CANS and ANSA shall be administered by a certified provider and through a collaborative process involving at minimum the member and caregiver (as applicable).
 - c. The IP-CANS and ANSA shall be completed at intake, every six months after the first administration, and at discharge.
 - d. The IP-CANS and ANSA shall reflect member improvement in three or more of the following domains: functioning, school, behavioral/emotional, strength behavior, risk behavior, and caregiver needs and strengths (the last of which is applicable to IP-CANS only).
 - e. For members involved with child-services agencies, including Santa Barbara County Child Welfare Services and Probation, Contractor shall provide a copy of the IP-CANS to the child-serving agencies upon completion of each IP-CANS with a valid, written authorization or release of information.
- ii. Pediatric Symptom Checklist. The Pediatric Symptom Checklist (PSC-35) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

- a. Contractor shall require a parent or caregiver to complete the PSC-35 for their children, age three years and up to 18 years.
 - b. The PSC-35 shall be completed at intake, every six months following the first administration, and at discharge.
- 2. **Collateral.** "Collateral" means a service activity to a significant support person(s) in a member's life for the purpose of meeting the needs of the member in terms of achieving the goals of the member's plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the member, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The member may or may not be present for this service activity. (Cal. Code of Regs., tit. 9, § 1810.206.)
 - i. Significant Support Person. "Significant support person" means a person(s), in the opinion of the member or the person providing services, who has or could have a significant role in the successful outcome of treatment including, but not limited to, the parents or legal guardian of a member who is a minor, the legal representative of a member who is not a minor, a person living in the same household as the member, the member's spouse, and relatives of the member. (Cal. Code of Regs., tit., § 1810.246.1.)
- 3. **Crisis Intervention.** "Crisis Intervention" is an unplanned, expedited service to or on behalf of a member to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. It may include contact with significant support person(s) or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, therapy, and referral and linkages. Crisis Intervention services may either be face-to-face or by telephone or telehealth and may be provided in a clinic setting or anywhere in the community. (State Plan, Supplement 3 to Attachment 3.1-A, page 2d [TN 22-0023].)

- 4. Intensive Care Coordination (ICC).** “Intensive Care Coordination (ICC)” is a targeted case management service that facilitates assessment of care planning for and coordination of services to members under the age of 21 years who are eligible for the full scope of Medi-Cal services and who meet medical criteria to access specialty mental health services. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model, including the establishment of the Child and Family Team (CFT), to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. The CFT is comprised of, as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the member plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:
- i. Ensures that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;
 - ii. Facilitates a collaborative relationship among the child, their family, and systems involved in providing services to the child;
 - iii. Supports the parent/caregiver in meeting their child's needs;
 - iv. Helps establish the CFT and provides ongoing support; and
 - v. Organizes and matches care across providers and child-serving systems to allow the child to be served in their community.
- 5. Intensive Home Based Services (IHBS).** “Intensive Home Based Services (IHBS)” are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child’s functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child’s family’s ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model by the Child and Family Team in coordination with the family’s overall service plan which may include IHBS. Service activities may include, but are not limited to, assessment, treatment plan, therapy, and rehabilitation and

include contact with significant support person(s) or other collaterals if the purpose of their participation is to focus on the treatment of the member. IHBS is provided to members under the age of 21 years who are eligible for the full scope of Medi-Cal services and who meet the access criteria for specialty mental health services.

6. **Medication Support Services.** “Medication Support Services” include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. This service includes one or more of the following service components: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; medication education including instruction in the use, risks, and benefits of and alternatives for medication; and treatment planning. Medication support services may include contact with significant support person(s) or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may be provided face-to-face, by telephone, or by telehealth and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.
7. **Peer Support Services.** “Peer Support Services” are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their conditions and the process of recovery.
 - i. Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting.
 - ii. Peer support services can include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the member by supporting the achievement of the member’s treatment goals.

- iii. Peer support services are based on an approved plan of care and may be delivered as a standalone service.
 - iv. Peer support services include one or more of the following service components:
 - a. Educational Skill Building Groups, which are groups provided in a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
 - b. Engagement, which means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and supporting members in developing their own recovery goals and processes.
 - c. Therapeutic Activity, which means structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support person(s). (State Plan, Supplement 3 to Attachment 3.1-A, page 2 [TN 22-0023].)
 - v. Peer Support Services may be provided face-to-face, by telephone, or by telehealth with the member or significant support person(s) and may be provided anywhere in the community.
- 8. Psychosocial Rehabilitation.** "Psychosocial Rehabilitation" means a recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member.

Psychosocial rehabilitation includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a member or a group of members. (State Plan, Supplement 3 to Attachment 3.1-A, page 2a [TN 22- 0023].)

- 9. Targeted Case Management.** “Targeted case management” is a service that assists a member in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure member access to services and the service delivery system; monitoring of the member’s progress, placement services, and plan development. Targeted case management services may be face-to-face or by telephone with the member or significant support person(s) and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the specialty mental health services program to be qualified to provide the service, consistent with the scope of practice and state law.
- 10. Referral and Linkage.** “Referral and Linkages” are services and supports to connect a member with primary care, specialty medical care, SUD treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22- 0023].)
- 11. Therapy.** “Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, and verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery, and resiliency to

assist a member in acquiring greater personal, interpersonal, and community functioning or to modify feelings, thought processes, conditions, attitudes, or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

12. Therapeutic Behavioral Services (TBS). “Therapeutic Behavioral Services (TBS)” are intensive, individualized, short-term outpatient treatment interventions for members up to the age of 21 years. Individuals receiving these services have serious emotional disturbances (SED) or are experiencing a stressful transition or life crisis and need additional short-term, specific support services.

13. Treatment Planning. “Treatment Planning” means a service activity to develop or update a member’s course of treatment, documentation of the recommended course of treatment, and monitoring a member’s progress. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

2. ADDITIONAL PROGRAM REQUIREMENTS.

A. Coordination of Services. Contractor shall provide services in coordination and collaboration with Behavioral Wellness, including Mental Health Services; Alcohol and Drug Program services, the County Probation Department; other County departments; and other community-based organizations, as applicable.

B. Timely Access to Services.

1. Contractor shall meet State standards for timely access to care and services, taking into account the urgency of the need for services.
2. Contractor shall make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.
3. Contractor shall have policies and procedures in place to screen for emergency medical conditions and immediately refer members to emergency medical care.

C. Accessibility. Contractor shall ensure that it provides physical access, reasonable accommodations, and accessible equipment for Medi-Cal member with physical or mental disabilities. (42 C.F.R. § 438.206(b)(1) and (c)(3).)

- D. Access to Routine Appointments.** Contractor shall provide access to routine appointments (1st appointment within 10 business days). When not feasible, Contractor shall give the member the option to re-contact the County's Access team toll free at (888) 868-1649 and request another provider who may be able to serve the member within the 10 business day standard.
- E. Hours of Operation.** Contractor shall maintain hours of operation during which services are provided to Medi-Cal members that are no less than the hours of operation during which Contractor offers services to non-Medi-Cal members. If Contractor only offers services to Medi-Cal members, maintain hours of operation which are comparable to the hours Contractor makes available for Medi-Cal services not covered by County or another Mental Health Plan.
- F. Member Assessment, Problem List, and Treatment Plan (or Treatment Plan Progress Note).** Contractor shall complete an Assessment, Problem List, and Treatment Plan (or Treatment Plan Progress Note for targeted case management and peer support services) for each member receiving Program services in accordance with CalAIM requirements, applicable Behavioral Wellness Policies and Procedures, and DMC-ODS and MHS documentation information available at [SmartCare & Documentation Resources | Santa Barbara County, CA - Official Website](#)
- G. Parity in Mental Health & Substance Use Disorder Benefits (42 C.F.R. § 438.900 et seq.)** To ensure compliance with the parity requirements set forth in 42 C.F.R. § 438.900 et seq., Contractor shall not impose, or allow its subcontractors, if any, to impose any financial requirements, Quantitative Treatment Limitations, or Non-Quantitative Treatment Limitations in any classification of benefit (inpatient, outpatient, emergency care, or prescription drugs) other than those limitations permitted and outlined in the Intergovernmental Agreement, Contract Number 24-40145.
- H. Member Satisfaction Surveys.** Contractor shall, assist the County in administering, announcing and collecting the member satisfaction surveys to members receiving services. The Member Satisfaction Survey (CPS) is for MHS programs, and the Treatment Perception Survey (TPS) is for alcohol and drug program members. It is administered to both youth (ages 12 to 17) and adults (ages 18 and older).
- I. Member Handbook.** Contractor shall provide the County of Santa Barbara Member Handbook to each potential member and member in an approved method listed in the *Department of Behavioral Wellness' Policy and Procedures #4.008*

Member Informing Materials when first receiving Alcohol and Drug Services DMC-ODS treatment services or Specialty Mental Health Services and upon request or upon request within five business days, and shall inform all members of where the information is placed on the County website in electronic form. Contractor shall document the date and method of delivery to the member in the member's file. Contractor shall inform member that information is available in alternate formats and how to access those formats. (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26, attachments 3, 4; Cal. Code Regs., tit. 9, § 1810.360, subd. (e); 42 C.F.R. § 438.10.)

J. Written Materials in English and Spanish. Contractor shall provide all written materials for member and potential member, including provider directories, County of Santa Barbara Member Handbook, appeal and grievance notices, denial and termination notices, and Santa Barbara County's mental health education materials, in English and Spanish as applicable. (42 C.F.R. § 438.10(d)(3).) Contractor shall maintain adequate supply of County-provided written materials and shall request additional written materials from County as needed.

K. Effective Communication with Individuals with Disabilities.

1. Contractor shall comply with all applicable federal, state, and local disability laws and requirements including, but not limited to, 28 Code of Federal Regulations section 35.160 et seq. and California Department of Health Care Services BHIN 24-007 and take appropriate steps to ensure effective communication with individuals with disabilities.
2. Contractor shall provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, including the provision of qualified interpreters and written materials in alternative formats, free of charge and in a timely manner, when such aids and services are necessary to ensure that individuals with disabilities have an equal opportunity to participate in or enjoy the benefits of Contractor's covered services, programs, and activities.
3. Contractor shall provide interpretive services and make member information available in the following alternative formats: Braille, audio format, large print (no less than 20-point font), and accessible electronic format (such as a data CD). In determining what types of auxiliary aids and services are necessary, Contractor shall give "primary consideration" to the individual's request of a particular auxiliary aid or service.
4. Contractor shall provide auxiliary aids and services including:

- i. Qualified interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
 - ii. Qualified Readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.
- 5. When providing interpretive services, Contractor shall use qualified interpreters to interpret for a member with a disability, whether through a remote interpreting service or an on-site appearance. A qualified interpreter for a member with a disability is an interpreter who:
 - i. Adheres to generally accepted interpreter ethics principals including member confidentiality; and
 - ii. Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology. For a member with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).
- 6. If Contractor provides a qualified interpreter for a member with a disability through VRI services, Contractor shall provide real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the

interpreter's face, arms, hands, and fingers, and the participating member's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

7. Contractor shall not require a member with a disability to provide their own interpreter. Contractor is also prohibited from relying on an adult or minor child accompanying a member with a disability to interpret or facilitate communication except when:
 - i. There is an emergency involving an imminent threat to the safety or welfare of the member or the public and a qualified interpreter is not immediately available; or
 - ii. The member with a disability specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.
 - iii. Prior to using a family member, friend, or, in an emergency only, a minor child as an interpreter for a member with a disability, Contractor shall first inform the member that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the member's confidentiality.
 - iv. Contractor shall ensure that the refusal of free interpreter services and the member's request to use a family member, friend, or a minor child as an interpreter is documented.
8. Contractor shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination based on disability.
- L. **Provider Directory.** Contractor shall maintain a provider directory on its agency website listing licensed individuals employed by the provider to deliver mental health services. Contract shall provide a paper form to members upon request. The provider directory must be updated at least monthly to include the following information:
 1. Provider's name;
 2. Provider's business address(es);
 3. Telephone number(s);

4. Email address;
5. Website as appropriate;
6. Specialty in terms of training, experience and specialization, including board certification (if any);
7. Services/ modalities provided;
8. Whether the provider accepts new members;
9. The provider's cultural capabilities;
10. The provider's linguistic capabilities;
11. Whether the provider's office has accommodations for people with physical disabilities;
12. Type of practitioner;
13. National Provider Identifier Number;
14. California License number and type of license; and
15. An indication of whether the provider has completed cultural competence training.

M. Department of Behavioral Wellness Policies and Procedures. Contractor shall comply with all applicable Department of Behavioral Wellness policies and procedures including those listed below. Department of Behavioral Wellness policies and procedures, available at [Policy Portal - Departmental - Smartsheet.com](https://policyportal.dhs.ca.gov/), and are incorporated herein by reference. Contractor agrees to comply with any changes to these policies and procedures that occur during the Term of this Agreement. This obligation shall apply without the need for an amendment(s) of this Agreement. If the parties amend the affected provisions of this Agreement to conform to the changes in the policies and procedures, the amendment shall be retroactive to the effective date of such changes to the policies and procedures.

1. **Policy and Procedure #2.001.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #2.001 Network Adequacy Standards and Monitoring.*
2. **Policy and Procedure #2.005.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #2.005 Accessibility for People with Disabilities.*

3. **Policy and Procedure #2.006.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #2.006 Language Services for Individuals with LEP.*
4. **Policy and Procedure #2.007.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #2.007 Cultural and Linguistic Competency.*
5. **Policy and Procedure #2.008.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #2.008 Nondiscrimination of Members.*
6. **Policy and Procedure #3.000.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #3.000 Member Rights.*
7. **Policy and Procedure #3.004.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #3.004 Advance Directives – Adult Outpatient Services* on advance directives and the County's obligations for Physician Incentive Plans, as applicable.
8. **Policy and Procedure #3.006.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #3.006 Warm Handoff.*
9. **Policy and Procedure #4.004.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.004 Unusual Occurrence Incident Reporting.*
10. **Policy and Procedure #4.008.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.008 Member Informing Materials.*
11. **Policy and Procedure #4.010.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.010 Notice of Adverse Benefits Determination.*
12. **Policy and Procedure #4.012.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.012 Contracted Provider Relations.*
13. **Policy and Procedure #4.014.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.014 Service Triage for Urgent and Emergency Conditions.*

- 14. Policy and Procedure #4.015.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.015 Staff Credentialing and Re-Credentialing*
- 15. Policy and Procedure #4.020.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.020 Member Problem Resolution Process.*
- 16. Policy and Procedure #5.008.** Mandatory Trainings Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #5.008 Mandatory Training.*
- 17. Policy and Procedure #7.005.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #7.005 Provider Monitoring.*
- 18. Policy and Procedure #8.009.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.009 Medication Consent for Adults.*
- 19. Policy and Procedure #8.100.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.100 Mental Health Client Assessment.*
- 20. Policy and Procedure #8.101.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.101 Client Problem Lists, Treatment Plans, and Treatment Progress Notes.*
- 21. Policy and Procedure #8.102.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.102 CalAIM Documentation Reform-Progress Note Requirements.*
- 22. Policy and Procedure #14.000.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #14.000 Information System for Workforce Access*
- 23. Policy and Procedure #14.004.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #14.004 Mail Encryption.*
- 24. Policy and Procedure #7.020.** (RESERVED)
- 25. Policy and Procedure #7.022.** (RESERVED)
- 26. Policy and Procedure #7.036.** (RESERVED)
- 27. Policy and Procedure #12.002.** (RESERVED)

Policies Applicable to MHS in addition to Policies 1- 23 listed above:

28. Policy and Procedure #4.000. Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.000 Authorization of Outpatient Specialty Mental Health Services.*

29. Policy and Procedure #4.001. Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.001 Authorization of Therapeutic Behavioral Services (TBS),* applicable to providers providing children services.

30. Policy and Procedure #4.021. (RESERVED)

31. Policy and Procedure #19.004. (RESERVED)

32. Policy and Procedure #19.007 (RESERVED)

33. Policy and Procedure #19.009 (RESERVED)

34. Policy and Procedure #19.011. (RESERVED)

N. Alcohol and Drug Programs. (RESERVED)

O. Mental Health Programs.

1. Mental Health Program Definition(s). The following term(s) as used throughout this Agreement shall have the meaning(s) as set forth below:

i. Medically Necessary or Medical Necessity.

a. For individuals 21 years of age or older, Pursuant to Welfare and Institutions Code section 14184.402(a), a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

b. For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to

ameliorate the mental health condition are thus medically necessary and covered as EPSDT services. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

3. **CONFIDENTIALITY.**

- A. Compliance with Privacy and Data Security Authorities.** Contractor shall, at its sole cost and expense, comply with all applicable federal, state, and local healthcare privacy and data security requirements and authorities including, but not limited to, those authorities specified in this Section (Confidentiality) now in force or which may hereafter be in force and shall develop and maintain comprehensive patient confidentiality policies and procedures, provide annual training of all staff regarding those policies and procedures, and demonstrate reasonable efforts to secure written and/or electronic data.
- B. Maintain Confidentiality.** Contractor agrees, and shall require its employees, agents, subcontractors, or contracted providers to agree, to maintain the confidentiality of patient records pursuant to: Title 42 United State Code (USC) Section 290 dd-2; Title 42 Code of Federal Regulations (C.F.R.), Part 2; Title 42 C.F.R. Section 438.224; 45 C.F.R. Section 96.132(e), 45 C.F.R. Parts 160, 162, and 164; Title 22 California Code of Regulations (CCR) Section 51009; Welfare & Institutions Code (W&IC) Section 5328 et seq. and Sections 14100.2 and 14184.102; Health and Safety Code (HSC) Sections 11812 and 11845.5; Civil Code Sections 56 – 56.37, 1798.80 – 1798.82, and 1798.85; and Exhibit D, Section 14 of the Intergovernmental Agreement Number 24-40145 to the extent that these requirements are applicable. Patient records must comply with all appropriate State and Federal requirements.
- C. No Publication of Member Lists.** Contractor shall ensure that no list of persons receiving services under this Agreement is published, disclosed, or used for any purpose except for the direct administration of services under this Agreement or other uses authorized by law that are not in conflict with requirements for confidentiality contained in the preceding codes.
- D. Member's Health Record.** Contractor shall maintain and share, as appropriate, a member's health record in accordance with professional standards. (42 C.F.R. § 438.208(b)(5).) Contractor shall ensure that, in the course of coordinating care, each member's privacy is protected in accordance with this Agreement all federal and state privacy laws, including but not limited to 45 C.F.R. parts 160 and 164,

subparts A and E, to the extent that such provisions are applicable. (42 C.F.R. § 438.208(b)(6).)

- E. Contractor shall comply with Exhibit F to the Integrated Intergovernmental Agreement to the extent Contractor is provided Personal Health Information (“PHI”), Personal Information (“PI”), or Personally Identifiable Information (“PII”) as defined in Exhibit F of the Integrated Intergovernmental Agreement from County to perform functions, services, or activities specified in this Agreement.
- F. Contractor shall make itself and any subcontractors, employees or agents assisting Contractor in the performance of its obligations under this Agreement, available to County or DHCS at no cost to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against County, DHCS, its directors, officers or employees based upon claimed violations of privacy involving inactions or actions by Contractor, except where Contractor or its subcontractor, employee or agent is a named adverse party.
- G. Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all PHI, PI and PII accessed in a database maintained by County, received by Contractor from County, or acquired or created by Contractor in connection with performing functions, services, or activities specified in this Agreement on behalf of County that Contractor still maintains in any form, and shall retain no copies of such PHI, PI or PII. If return or destruction is not feasible, Contractor shall notify County of the conditions that make the return or destruction infeasible, and County and Contractor shall determine the terms and conditions under which Contractor may retain the PHI, PI or PII. Contractor shall continue to extend the protections of Exhibit F of the Integrated Intergovernmental Agreement to such PHI, PI and PII, and shall limit further use of such data to those purposes that make the return or destruction of such data infeasible. This subsection shall also apply to Department PHI, PI and PII that is in the possession of subcontractors or agents of Contractor.

4. **MEMBER AND FAMILY MEMBER EMPOWERMENT.**

- A. **Support Active Involvement.** Contractor agrees to support active involvement of members and their families in treatment, recovery, and policy development.
- B. Contractor shall actively participate in the planning design, and execution of County’s Quality Improvement Program as described in Cal. Code. Regs., Title 9, § 1810.440(a)(2)(A).
- C. Contractor shall comply with *Department of Behavioral Wellness’ Policy and Procedure #3.000 Member Rights*, available at [County of Santa Barbara](#)

Behavioral Wellness PR 3.000 Member Rights and ensure that its employees and/or subcontracted providers observe and protect those rights.

D. Maintain Grievance Policy/Procedure. Contractor shall adopt *Department of Behavioral Wellness' Policy and Procedures #4.020 Member Problem Resolution Process*, available at www.countyofsb.org/behavioral-wellness, to address member/family complaints in compliance with member grievance, appeal, and fair hearing procedures and timeframes as specified in 42 C.F.R. Section 438.400 through 42 C.F.R. Section 438.424.

E. Contractor shall obtain and retain a written medication consent form signed by the member in accordance with *Department of Behavioral Wellness' Policy and Procedures #8.009 Medication Consent for Adults* to the extent Contractor is a "provider" as defined by the Integrated Intergovernmental Agreement.

5. NOTIFICATION REQUIREMENTS.

A. Notice to QCM. Contractor shall immediately notify Behavioral Wellness Quality Care Management ("QCM") Division at 805-681-4777 or by email at BWELLQCM@sbcbswell.org in the event of:

1. Known serious complaints against licensed/certified staff;
2. Restrictions in practice or license/certification of staff as stipulated by a State agency;
3. Staff privileges restricted at a hospital;
4. Other action instituted which affects staff license/certification or practice (for example, sexual harassment accusations); or
5. Any event triggering Incident Reporting, as defined in *Behavioral Wellness Policy and Procedure #4.004, Unusual Occurrence Reporting*.

B. Notice to Compliance Hotline. Contractor shall immediately contact the Behavioral Wellness Compliance Hotline (805-884-6855) should any of the following occur:

1. Suspected or actual misappropriation of funds under Contractor's control;
2. Legal suits initiated specific to the Contractor's practice;
3. Initiation of criminal investigation of the Contractor; or
4. Breach of Privacy Laws.

C. Notice to Case Manager/Regional Manager/Staff. For members receiving direct services from both Behavioral Wellness and Contractor staff, Contractor shall

immediately notify the member's Behavioral Wellness Case Manager or other Behavioral Wellness staff involved in the member's care, or the applicable Regional Manager should any of the following occur:

1. Side effects requiring medical attention or observation;
2. Behavioral symptoms presenting possible health problems; or
3. Any behavioral symptom that may compromise the appropriateness of the placement.

D. Definition of "Immediately." "Immediately" means as soon as possible but in no event more than twenty-four (24) hours after the triggering event. Contractor shall train all personnel in the use of the Behavioral Wellness Compliance Hotline (805-884-6855).

E. Notice to Contracts Division. Contractor may contact Behavioral Wellness Contracts Division at bwellcontractsstaff@sbcbswell.org for any contractual concerns or issues.

F. Written Notice of Termination to Members. Contractor shall make a good faith effort to give written notice of termination of Contractor as a provider of services to each member who was seen on a regular basis by Contractor. The notice to the member and a copy of each such notice to the County shall be provided 30 calendar days prior to the effective date of the termination of this Agreement or 15 calendar days after receipt or issuance of the notice of termination of this Agreement, whichever is later.

G. Contractor shall post taglines in any documents that are vital or critical to obtaining services and/or benefits, conspicuous physical locations where Contractor interacts with the public, on Contractor's website in a location that allows any visitor to the website to easily locate the information, and in all member information and other information notice, in accordance with federal and state requirements.

6. CULTURAL COMPETENCE.

A. Report on Capacity. Contractor shall report on its capacity to provide culturally competent services to culturally diverse members and their families upon request from County, including:

1. The number of bilingual and bicultural staff (as part of the quarterly staffing report), and the number of culturally diverse members receiving Program services; and

2. Efforts aimed at providing culturally competent services such as trainings provided to staff, changes or adaptations to service protocol, community education/outreach, etc.

B. Communicate in Preferred Language. At all times, the Contractor's Program(s) shall be staffed with personnel who can communicate in the member preferred language, or Contractor shall provide interpretation services, including American Sign Language (ASL).

C. Bilingual Staff for Direct Service Positions. Contractor will strive to fill direct service positions with bilingual staff in County's threshold language (Spanish) that is reflective of the specific needs of each region. Contractor percentage goals are calculated based on U.S. Census language data by region: Santa Barbara service area (including Goleta and Carpinteria) – 31%; Santa Maria service area (including Orcutt and Guadalupe) – 60%; and Lompoc service area (including Buellton and Solvang) – 41%.

D. Cultural Considerations When Providing Services. Contractor shall provide services that consider the cultural aspects of mental illness, as well as the ethnic and cultural diversity of members and families served. Additionally, any materials provided to the public must be printed in Spanish (threshold language).

E. Services and Programs in Spanish. Services and programs offered in English must also be made available in Spanish, if members identify Spanish as their preferred language, as specified in subsection B above.

F. As applicable, a measurable and documented effort must be made to conduct outreach to and to serve the marginalized, underserved, and non-served communities of Santa Barbara County.

G. Contractor shall establish a process by which Spanish speaking staff who provide direct services in Spanish or interpretive services are tested for proficiency in speaking, reading, and writing in the Spanish language.

7. COMPLIANCE PROGRAM.

A. If Contractor identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying County, Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

B. County shall suspend payments to Contractor when it or the State determines there is a credible allegation of fraud. Contractor shall implement and maintain arrangements or procedures that include provision for the suspension of

payments to independent contractors for which the State, or County, determines there is a credible allegation of fraud. (42 C.F.R. §§ 438.608(a), (a)(8) and 455.23.)

- C.** Contractor shall notify County within 30 calendar days when it has identified payments in excess of amounts specified for reimbursements of Medi-Cal services or when it has identified or recovered overpayments due to potential fraud. (42 C.F.R. § 438.608(a), (a)(2).) Contractor shall return any overpayments pursuant to Exhibit B, Section VII.G (Overpayments) of this Agreement.

SECTION III. PROGRAM OPERATIONS REQUIREMENTS

1. STAFF.

- A. Staff Background Investigations.** At any time prior to or during the term of this Agreement, the County may require that Contractor staff performing work under this Agreement undergo and pass, to the satisfaction of County, a background investigation, as a condition of beginning and continuing to work under this Agreement. County shall use its discretion in determining the method of background clearance to be used. The fees associated with obtaining the background information shall be at the expense of the Contractor, regardless if the Contractor's staff passes or fails the background clearance investigation.
- B. Consent to Criminal Background Check, Fingerprinting (42 C.F.R. § 455.450, Welf. & Inst. Code, § 14043.38).** Contractor consents to criminal background checks, including fingerprinting when required to do so by federal or state law. Within 30 days of a request from CMS or DHCS, Contractor, or any person with a 5% or more direct or indirect ownership interest in Contractor, shall submit a set of fingerprints in a form and manner determined by CMS or DHCS.
- C. Mandatory Termination.** As determined by DHCS, Contractor may be subject to mandatory termination from the Medi-Cal program for any of the following reasons:
- 1.** Failure to cooperate with and provide accurate, timely information in response to all required Medi-Cal screening methods, including failure to submit fingerprints as required (42 C.F.R. § 455.416); or
 - 2.** Conviction of a criminal offense related to a person's involvement with Medicare, Medi-Cal, or any other Title XX or XXI program in the last 10 years (42 C.F.R. § 455.416, 42 C.F.R. § 455.106).
- D. Staff Removal for Good Cause Shown.** County may request that Contractor's staff be immediately removed from performing work under this Agreement for good

cause during the term of the Agreement. Upon such request, Contractor shall remove such staff immediately.

- E. Denial or Termination of Facility Access.** County may immediately deny or terminate County facility access, including all rights to County property, computer access, and access to County software, to Contractor's staff that does not pass such investigation(s) to the satisfaction of the County, or whose conduct is incompatible with County facility access.
- F. Staff Disqualification.** Disqualification, if any, of Contractor staff, pursuant to this Section regarding Staff or any other provision of law, shall not relieve Contractor of its obligation to complete all work in accordance with the terms and conditions of this Agreement.
- G. Notice of Staffing Changes Required.** Contractor shall notify QCM at BwellQCM@sbcbswell.org and BWell Contracts at bwellcontractsstaff@sbcbswell.org immediately when staff unexpectedly separates from employment or is terminated, or within 30 days of the expected last day of employment for staff planning a formal leave of absence in alignment with the *Policy 14.000 Information Systems for Workforce Access and Termination* at [County of Santa Barbara Behavioral Wellness Policy 14.000 Information Systems for Workforce Access and Termination](#). Additionally, Contractor shall notify County of any staffing changes as part of the quarterly Staffing Report, in accordance with Section 5.C. (Reports).
- H. Email Domain.** Contractor and its staff shall use Contractor's business email domain to log into the Department of Behavioral Wellness electronic health record.
- I.** Contractor shall notify County through the ServiceNow CBO Onboarding/Offboarding Portal within one business day for the unexpected termination of staff when staff separates from employment or is terminated from working under this Agreement, or within one week of the expected last day of employment or for staff planning a formal leave of absence.
- J.** All staff performing services under this Agreement with access to the Department of Behavioral Wellness electronic health record shall be reviewed and approved by Behavioral Wellness Quality Care Management (QCM) Division, in accordance with *Behavioral Wellness Policy and Procedure #4.015, Staff Credentialing and Re-Credentialing*.
- K. Alcohol and Drug Programs.**

- 1. Experienced Staff for Direct Member Services.** Staff hired to work directly with members shall have competence and experience in working with members with substance use disorders and co-occurring disorders.

L. Mental Health Service Programs.

1. Contractor staff providing direct services to members shall be trained and skilled at and provided with the required supervision of service delivery in working with persons with serious mental illness (SMI) and shall adhere to professionally recognized evidence-based best practices for rehabilitation assessment, service planning, and service delivery. In addition, these staff shall receive Documentation Training in accordance with the *Behavioral Wellness Mandatory Trainings Policy and Procedure #5.008*, as may be amended, available at [County of Santa Barbara Behavioral Wellness Mandatory Trainings Policy and Procedure #5.008](#).
2. Contractor shall ensure that any staff identified on the Centers for Medicare & Medicaid Services (“CMS”) Exclusions List or other applicable list shall not provide services under this Agreement nor shall the cost of such staff be claimed to Medi-Cal. Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either sections 1128 or 1128A of the Social Security Act.

M. Staffing Definitions. The following terms shall have the meanings as set forth below of the types of providers that can provide Drug Medi-Cal Organized Delivery Services and Specialty Mental Health and in accordance with SPA 23-0026, BHIN 24-023 and Title 9 and Title 22 CCR:

- 1. Licensed Mental Health Professional (LMHP)/Licensed Professional of the Healing Arts (LPHA).** “Licensed mental health professional/Licensed Professional of the Healing Arts” means any of the following providers who are licensed in accordance with applicable State of California licensure requirements:
 - i. licensed physicians;
 - ii. licensed psychologists (includes waived psychologists);
 - iii. licensed clinical social workers (includes waived or registered clinical social workers);
 - iv. licensed professional clinical counselor (includes waived or registered professional clinical counselors);

- v. licensed marriage and family therapists (includes waived or registered marriage and family therapists);
- vi. registered nurses (includes certified nurse specialists and nurse practitioners);
- vii. licensed vocational nurses;
- viii. licensed psychiatric technicians; and
- ix. licensed occupational therapists. (State Plan, Supplement 1 to Attachment 3.1.-A, page 11 [TN 23-0026]; BHIN 24-023.)

2. Waivered/Registered Professional. “Waivered/Registered Professional” means:

- i. For a psychologist candidate, “waivered” means an individual who either is gaining the experience required for licensure or was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by the California Department of Health Care Services to the extent authorized under state law.
- ii. For a social worker candidate, a marriage and family therapist candidate, or a professional clinical counselor candidate, “registered” means a candidate for licensure who is registered or is in the process of obtaining registration in accordance with the criteria established by the corresponding state licensing authority for the purpose of acquiring the experience required for licensure in accordance with applicable statutes and regulations and “waivered” means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination, and who has been granted a professional licensing waiver approved by the California Department of Health Care Services to the extent authorized under state law. (State Plan TN: 23-0026; BHIN 24-023.)

3. Clinical Trainee. “Clinical Trainee” means an unlicensed individual who is enrolled in a postsecondary educational program that is required for the individual to obtain licensure as a Licensed Mental Health Professional; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or the applicable licensing board to participate in the practicum, clerkship, or internship and provide specialty mental health services

including, but not limited to, all coursework and supervised practice requirements. Clinical Trainee provider types include:

- i. Nurse Practitioner Clinical Trainee;
- ii. Licensed Psychologist Clinical Trainee;
- iii. Licensed Clinical Social Worker Clinical Trainee;
- iv. Licensed Marriage and Family Therapist Clinical Trainee;
- v. Licensed Professional Clinical Counselor Clinical Trainee;
- vi. Licensed Psychiatric Technician Clinical Trainee;
- vii. Registered Nurse Clinical Trainee;
- viii. Licensed Vocational Nurse Clinical Trainee;
- ix. Licensed Occupational Therapist Clinical Trainee;
- x. Licensed Physician Clinical Trainee (Medical Student);
- xi. Registered Pharmacist Clinical Trainee;
- xii. Physician Assistant Clinical Trainee; and
- xiii. (Certified) Clinical Nurse Specialist Clinical Trainee (specialty mental health delivery system only). (State Plan TN: 23-0026; BHIN 24-023.)

4. Medical Assistant. “Medical Assistant” is an individual who is at least 18 years of age, meets all applicable education, training and/or certification requirements, and provides administrative, clerical, and technical supportive services according to their scope of practice, under the supervision of a licensed physician and surgeon, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician and surgeon, nurse practitioner or physician assistant must be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant. (State Plan TN: 23-0026; BHIN 24-023.)

5. Peer Support Specialist. “Peer Support Specialist” means an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification who meets ongoing education requirements and provides services under the direction of a Behavioral Health Professional. (State Plan, Supplement 3 to Attachment 3.1-A, page 2j [TN 22-0026].)

6. Alcohol Drug Programs. (RESERVED)

7. Mental Health Services Programs.

- i. Community Health Worker. Community Health Worker is a skilled and trained health educator who is member of the community they serve who link members to health, mental health and social services to improve the overall quality of services delivered. CHWs may include individuals known by a variety of job titles who meet the CHW qualifications as APL 24-006; State Plan 22-0001 and as defined in BHIN 25-028, BHIN 21-073; access criteria for DMC services, defined in BHIN 21-071; and/or access criteria for DMC-ODS services, defined in BHIN 24-001, or subsequent guidance.
- ii. Mental Health Rehabilitation Specialist. “Mental Health Rehabilitation Specialist” is defined in *Behavioral Wellness Policy and Procedure #4.015, Staff Credentialing and Re-Credentialing*.
- iii. Qualified Mental Health Worker. “Qualified Mental Health Worker” is defined in *Behavioral Wellness Policy and Procedure #4.015, Staff Credentialing and Re-Credentialing*.
- iv. Mental Health Worker. “Mental Health Worker” is defined in *Behavioral Wellness Policy and Procedure #4.015, Staff Credentialing and Re-Credentialing*.

2. LICENSES, PERMITS, REGISTRATIONS, ACCREDITATIONS, AND CERTIFICATIONS.

- A. **Confirmation of Staff Licensure/Certification**. In the event license/certification status of a staff member cannot be confirmed, the staff member shall be prohibited from providing services under this Agreement per *Department Policy #4.015 Staff Credentialing and Re-Credentialing*.
- B. **Enrollment with DHCS as Medicaid Provider**. Contractor shall be at all times currently enrolled with the California Department of Health Care Services as a Medicaid provider, consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. part 455, subparts B and E.
- C. **Alcohol and Drug Programs**.(RESERVED)
 - 1. **Obtain and Maintain Required Credentials**. Contractor shall obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, accreditations, and certificates (including, but not limited to, certification as a Drug Medi-Cal provider if Title 22 California Code of Regulations (C.C.R.) Drug Medi-Cal services are provided hereunder), as required by all Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines, and directives, which are applicable to Contractor’s

facility(s) and services under this Agreement. A copy of such documentation shall be provided to Behavioral Wellness QCM Division upon request. Contractor shall further ensure that all of its officers, employees, and agents, who perform services hereunder, shall obtain and maintain in effect during the term of this Agreement all licenses, permits, registrations, accreditations, and certificates which are applicable to their performance hereunder. A copy of such documentation shall be provided to the Department of Behavioral Wellness Quality Care Management in alignment with *Department Policy #4.015 Staff Credentialing and Re-Credentialing*.

- 2. Pre-Registration Requirements for New AOD Counselors.** Contractor shall follow the pre-registration requirements for new alcohol and other drug (AOD) counselors in California. California law requires registration and certification of individuals providing AOD counseling services, as specified in Title 9 C.C.R., Division 4, Chapter 8, Section 13000 et seq. (This new requirement does NOT apply to counselors already registered with or certified by State approved and nationally-accredited agencies, or to interns registered with the California Board of Psychology or the California Board of Behavioral Sciences, in accordance with Title 9 C.C.R., Section 13015).
- 3. Reduction of Services or Relocation.** Contractor shall not implement any reduction of covered services or relocations until the approval is issued by DHCS. Within 35 days of receiving notification of Contractor's intent to reduce covered services or relocate, the County shall submit, or require Contractor to submit, a DMC certification application to Provider Enrollment Division (PED). The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
- 4. Keep Informed of Current Guidelines.** If Contractor is a participant in the Drug Medi-Cal Organized Delivery System, Contractor shall keep fully informed of all current guidelines disseminated by the Department of Health Care Services (DHCS), Department of Public Health (DPH) and Department of Social Services (DSS), as applicable, including, but not limited to, procedures for maintaining Drug Medi-Cal certification of all its facilities in alignment with DHCS rules and regulations.
- 5. Enrollment in DATAR.** By its signature on this Agreement, Contractor attests that it is enrolled in DATAR at the time of execution of this Agreement.

D. Mental Health Service Programs.

1. **Obtain and Maintain Required Credentials.** Contractor shall obtain and maintain in effect during the term of this Agreement, all licenses, permits, registrations, accreditations, and certifications (including, but not limited to, certification as a Short-Doyle/Medi-Cal provider if Title XIX Short-Doyle/Medi-Cal services are provided hereunder), as required by all Federal, State, and local laws, ordinances, rules, regulations, manuals, guidelines, and directives, which are applicable to Contractor's facility(ies) and services under this Agreement. Contractor shall further ensure that all of its officers, employees, and agents, who perform services hereunder, shall obtain and maintain in effect during the term of this Agreement all licenses, permits, registrations, supervision agreements, accreditations, and certificates which are applicable to their performance hereunder. A copy of such documentation shall be provided to Behavioral Wellness QCM Division, upon request.
2. **Short-Doyle/Medi-Cal Program.** If Contractor is a participant in the Short-Doyle/Medi-Cal program, Contractor shall keep fully informed of and in compliance with all current Short-Doyle/Medi-Cal Policy Letters, including, but not limited to, procedures for maintaining Medi-Cal certification of all its facilities, and the requirements of *Department of Behavioral Wellness' Policy and Procedure #4.005 – Site Certification for Specialty Mental Health Services*.
3. **Medicare "Opt-Out".** If any of the Contractor's eligible licensed practitioners have submitted a Medicare "Opt-Out" affidavit and are therefore opted-out of Medicare, these practitioners' services cannot be billed to Medicare and are not billable to Medi-Cal.

3. **TRAINING REQUIREMENTS.**

- A. **Training Upon Hire and Annually Thereafter.** Contractor shall ensure that all staff providing ADP, MHS, BHSA and SUBG services under this Agreement complete mandatory trainings, including through attendance at County-sponsored training sessions as available. The following trainings must be completed at hire and annually thereafter:
 1. Behavioral Wellness Code of Conduct;
 2. Consumer and Family Culture;
 3. Cultural Competency; and
 4. HIPAA Privacy and Security.
- B. **Alcohol and Drug Programs Additional Trainings.** (RESERVED)

1. *ASAM Multidimensional Assessment* by the Change Companies (only required once prior to providing DMC-ODS services);
2. *From Assessment to Service Planning and Level of Care* by the Change Companies (only required once prior to providing DMC-ODS services);
3. DMC-ODS Documentation Training; and County Department of Behavioral Wellness electronic health record (EHR), including SmartCare for service and administrative staff who enter and analyze data in the system (at hire and as needed).
4. DMC-ODS Continuum of Care Training;
5. Motivational Interviewing Training;
6. Cognitive Behavioral Treatment/Counseling Training;
7. Seeking Safety (training provided by County) or other trauma-informed services where indicated; and
8. All applicable evidence-based prevention models and programs as agreed upon between provider and County in writing.
9. **CEU Hours Alcohol and Other Drug Clinical Training:**
 - i. All direct service staff who provide direct SUD treatment services are required to complete a minimum of 18 Continuing Education Units (CEU) hours of alcohol and other drug specific clinical training per year; training shall be documented in the personnel records.
 - ii. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year; training shall be documented in the personnel records.
10. **Continuing Medical Education in Addiction Medicine.** Contractor physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year; training shall be documented in the personnel records.
11. **Overdose Prevention Training.** Contractor shall:
 - i. Ensure all direct treatment staff become familiar with overdose prevention principles and techniques, including through trainings and materials provided by Behavioral Wellness; and
 - ii. Make available and distribute prevention overdose materials, as provided by Behavioral Wellness, to all staff and members.

12. Experienced Staff for Direct Member Services. Staff hired to work directly with members shall have competence and experience in working with members with substance use disorders and co-occurring disorders.

C. Alcohol and Drug Program Treatment and Prevention Programs Additional Trainings. (RESERVED)

D. Mental Health Service Programs Additional Trainings.

1. Behavioral Wellness electronic health record (EHR), including SmartCare for service and administrative staff who enter and analyze data in the system (at hire and as needed); and
2. MHSA Overview Training (only at hire, not annually).
3. Training Requirements for Contractor staff who provide direct services/document in Behavioral Wellness electronic health record (EHR), including SmartCare. The following trainings must be completed at hire and annually thereafter:
 - i. Documentation Training;
 - ii. Child and Adolescent Needs and Strengths (IP-CANS) or Adult Needs and Strengths (ANSA) assessment training and certification exam:
 - a. Contractors who provide services to members ages zero through 20 years old shall complete the IP-CANS certification training and exam.
 - b. Contractors who provide services to members ages 21 years old and older shall complete the ANSA.
 - c. Contractors providing services to members of both age groups may select either of these assessment tool trainings and need not compete both; and
 - d. Annual training and certification of clinicians is required for use of the IP-CANS or ANSA. In order to be certified in the IP-CANS or ANSA clinicians must demonstrate reliability on a case vignette of .70 or greater.
4. Any additional applicable trainings in accordance with the *Behavioral Wellness Mandatory Trainings Policy and Procedure #5.008*, as may be amended, available at [County of Santa Barbara Behavioral Wellness Mandatory Trainings Policy and Procedure #5.008](#).

4. COLLABORATIVE MEETINGS.

- A. Behavioral Wellness may conduct a Collaborative Meeting annually, or more frequently, if needed, and bi-monthly County Quality Improvement Committee (QIC) meetings which Contractor shall attend to collaboratively discuss programmatic, fiscal, and contract matters.

5. **REPORTS.**

- A. **Annual Mandatory Training Report.** Contractor shall submit, no later than June 15th of each year unless requested earlier by County, to the County Training Coordinator evidence of completion of the Mandatory Trainings identified in the Section regarding Training Requirements.

- B. **Programmatic.** Contractor shall submit quarterly programmatic reports to County, which shall be received by County no later than 25 calendar days following the end of the quarter being reported. Programmatic reports shall include the following:

1. Contractor shall state whether it is or is not progressing satisfactorily in achieving all the terms of this Agreement and if not, shall specify what steps will be taken to achieve satisfactory progress;
2. Contractor shall include a narrative description of Contractor's progress in implementing the provisions of this Agreement, details of outreach activities and their results, any pertinent facts or interim findings, staff changes, status of Licenses and Certifications, changes in population served and reasons for any such changes;
3. The number of active cases and number of members admitted/ discharged;
4. The Measures described in the Exhibit A(s) Section 15. Program Goals, Outcomes, and Measures, as applicable, as applicable, or as otherwise agreed by Contractor and County. Contractor shall comply with amendments or modifications to Exhibit A(s) that do not alter the maximum contract amount of the Agreement and are authorized by the Director of the Department of Behavioral Wellness or designee in writing. This obligation shall apply without the need for an amendment of this Agreement. In addition, Contractor may include in its report any other data that demonstrates the effectiveness of Contractor's programs; and
5. In addition, Contractor may include any other data that demonstrates the effectiveness of Contractor's programs; and any other program specific reporting requirement, if any, as described in the individual programmatic Statement of Work Exhibits.

- C. Staffing.** Contractor shall submit quarterly Staffing Reports to County. These reports shall be on a form acceptable to, or provided by the County, and shall report actual staff hours worked by position and shall include the employees' names, licensure status, bilingual and bicultural capabilities, budgeted monthly salary, actual salary, hire date, and, if applicable, termination date. The reports shall be received by County no later than 25 calendar days following the end of the quarter being reported.
- D. Network Adequacy Certification Tool (NACT).** Contractor shall submit all required information to the County in order to comply with the *Department's Policy and Procedure #2.001 Network Adequacy Standards and Monitoring*. Network data reporting shall be submitted to QCM ADP BwellQCM@sbcbswell.org as required by the State Department of Health Care Services.
- E.** Contractor agrees that County or the California Department of Health Care Services (DHCS) may withhold payments until Contractor has submitted any required data and reports to County or DHCS as identified in this Agreement, or Integrated Intergovernmental Agreement, Exhibit A(s) or Document 1F(a) Reporting Requirement Matrix for Counties.
- F.** Contractor shall maintain records and make statistical reports as required by County and DHCS or other government agency, on forms provided by or acceptable to the requesting agency. In addition to reports required under this Agreement, upon County's request, Contractor shall make additional reports or provide other documentation as required by County concerning Contractor's activities as they affect the services hereunder. County will be specific as to the nature of information requested and allow 30 days for Contractor to respond.
- G.** As a condition of funding for Quality Assurance (QA) activities, Contractor QA staff shall provide a monthly report to QCM consisting of documentation reviews performed, associated findings, and corrective action. The QA reports shall be received by County no later than 30 calendar days following the end of the month being reported.
- H. Additional Reports.** Contractor shall maintain records and make statistical reports as required by County, State Department of Health Care Services (DHCS), Department of Public Health (DPH) or Department of Social Services (DSS), as applicable, on forms provided by or acceptable to, the requesting agency. Upon County's request, Contractor shall make additional reports as required by County concerning Contractor's activities as they affect the services hereunder. County

will be specific as to the nature of information requested and allow 30 days for Contractor to respond.

I. Alcohol and Drug Programs. (RESERVED)

J. Alcohol and Drug Prevention Programs. (RESERVED)

6. MONITORING.

A. County Monitoring Process. Contractor agrees to abide by the *Department of Behavioral Wellness' Policies and Procedures* referenced in Section 2.2 (Additional Program Requirements) and to cooperate with the County's utilization review process which ensures medical necessity, appropriateness and quality of care. This review may include clinical record peer review, member survey, and other program monitoring practices, as required by the Integrated Intergovernmental Agreement. Contractor shall cooperate with these programs, and shall furnish necessary assessment, clinical documentation and treatment plan if applicable, subject to Federal or State confidentiality laws, and provisions of this Agreement.

B. Periodic Review Meetings with Contractor. Contractor shall identify a senior staff member who will be the designated Behavioral Wellness QCM Division contact and will participate in any provider QCM meetings to review current and coming quality of care issues, documentation, fiscal and overall performance activity. Behavioral Wellness staff shall conduct periodic on-site reviews of Contractor's facility and program.

C. County Corrective Action Plan. County shall provide a corrective action plan and a timeline for implementation and/or completion of corrective action if deficiencies in Contractor's compliance with the provisions of the Integrated Intergovernmental Agreement or this Agreement are identified by County. Contractor shall:

1. Take corrective action;
2. Provide evidence of correction; and
3. Have a mechanism for monitoring effectiveness of corrective action over time.

D. Contractor shall be liable to County for any penalties assessed against County for Contractor's failure to comply with the required corrective action. County shall monitor the performance of Contractor on an ongoing basis for compliance with the terms of the Integrated Intergovernmental Agreement and this Agreement. County shall assign senior management staff as contract monitors to coordinate periodic review meetings with Contractor's staff regarding quality of clinical services, fiscal and overall performance activity, and provider recertification

requirements. County's Care Coordinators, Quality Improvement staff, and the Program Managers or their designees shall conduct periodic on-site and/or electronic reviews of Contractor's clinical documentation.

- E.** Contractor shall allow DHCS, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and its subcontractors', performance under this Agreement, including the quality, appropriateness, and timeliness of services provided. This right shall exist for 10 years from the term end date of this Agreement or in the event the Contractor has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. § 438.3(h).) If monitoring activities identify areas of non-compliance, Contractor will be provided with recommendations and a corrective action plan.

SECTION IV. ADMINISTRATIVE REQUIREMENTS

- 1. MEDI-CAL VERIFICATION.** Contractor shall be responsible for verifying member's County of Santa Barbara Medi-Cal eligibility or Drug Medi-Cal status and will take steps to reactivate or establish eligibility where none exists.
- 2. SITE STANDARDS.** (Applicable to MHS services.)
 - A.** Contractor agrees to comply with all Medi-Cal requirements, including, but not limited to those specified in the *Department of Behavioral Wellness' Policies and Procedures* referenced in Section 2.2 (Additional Program Requirements), and be approved to provide Medi-Cal services based on Medi-Cal site certification, per *Department of Behavioral Wellness' Policy and Procedure #4.005- Site Certification for Specialty Mental Health Services*.
 - B.** For programs located at Contractor's sites, Contractor shall develop and maintain a written disaster plan for the Program site and shall provide annual disaster training to staff that addresses, at a minimum: emergency staffing levels for the continuation of services under the Program, patient safety, facility safety, safety of medication storage and dispensing medication, and protection of member records, as required by this Agreement.
- 3. SIGNATURE PAD.** (RESERVED)

SECTION V. FEDERAL AND STATE CONTRACT COMPLIANCE REQUIREMENTS

- 1. STATE CONTRACT COMPLIANCE REQUIREMENTS.**

- A.** County and the California Department of Health Care Services (DHCS) may fully or partially revoke this Agreement or the delegated activities or obligations, or apply other remedies permitted by federal or state law when County or DHCS determine that Contractor has not performed satisfactorily (42 C.F.R. § 438.230(c)(2).)
- B.** Contractor shall comply with any applicable provision identified in the Integrated Intergovernmental Agreement as applying to subcontractors or contracted providers.
- C. Americans with Disabilities Act.** Contractor agrees to ensure that deliverables developed and produced pursuant to this Agreement shall comply with the accessibility requirements of sections 7405 and 11135 of the California Government Code, section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), regulations implementing the Rehabilitation Act of 1973 as set forth in part 1194 of title 36 of the Code of Federal Regulations, and the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.). In 1998, Congress amended the Rehabilitation Act of 1973 to require federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code sections 7405 and 11135 codify section 508 of the Rehabilitation Act of 1973 requiring accessibility of EIT.
- D. Generative Artificial Intelligence Technology Uses and Reporting.**
 - 1.** Contractor certifies its services or work under this Agreement does not include or make available any Generative Artificial Intelligence (GenAI) technology including GenAI from third parties or subcontractors.
 - 2.** During the Term of this Agreement, Contractor shall notify County in writing if its services or any work under this Agreement includes or makes available any previously unreported GenAI technology including GenAI from third parties or subcontractors. Contractor shall immediately complete the GenAI Reporting and Factsheet (STD 1000), available at [STD 1000 Generative Artificial Intelligence \(GenAI\) Disclosure & Factsheet](#) and submit the completed form to County to report the use of any new or previously unreported GenAI technology.
 - 3.** At the direction of County, Contractor shall discontinue the use of any new or previously undisclosed GenAI technology that materially impacts functionality, risk, or contract performance until use of such GenAI technology has been approved by County.

4. Contractor acknowledges and agrees that its failure to disclose GenAI technology use and submit the GenAI Reporting and Factsheet (STD 1000) to County may be considered a material breach of this Agreement by County or the California Department of Health Care Services (DHCS), and County or DHCS may consider the failure to disclose GenAI technology use and/or submit the GenAI Reporting and Factsheet (STD 1000) to County as grounds for the immediate termination of this Agreement. County and DHCS are entitled to seek all the relief to which they may be entitled as a result of such non-disclosure.
5. Contractor shall include subsection D (Generative Artificial Intelligence Technology Uses and Reporting) of this Section (Federal and State Contract Compliance Requirements) in all subcontracts to perform work under this Agreement.

E. Prohibited Affiliations.

1. Contractor shall not knowingly have any prohibited type of relationship, as described in subsection E.3 of this Section 5.1 (Federal and State Contract Compliance Requirements), with individuals or entities listed in subsection E.1.i and ii. Contractor shall further require that its subcontractors and contracted providers abide by this requirement.
 - i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. (42 C.F.R. § 438.610(a)(1).)
 - ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. section 2.101, of a person described in subsection E.1.i. (42 C.F.R. § 438.610(a)(2).)
2. Contractor, its contracted providers, and its subcontractors shall not have a prohibited type of relationship by employing or contracting with providers or other individuals and entities excluded from participation in federal health care programs (as defined 42 United States Code [U.S.C.] § 1320a-7b(f)) pursuant to 42 U.S.C. sections 1320a-7, 1320a-7a, 1320c-5, and 1395u(j)(2). (42 C.F.R. §§ 438.214(d)(1), 438.610(b).)
3. Contractor, its contracted providers, and its subcontractors shall not have the types of relationships prohibited by this subsection E.3 with an excluded, debarred, or suspended individual, provider, or entity.

- i. A director, officer, agent, managing employee, or partner of Contractor. (42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1).)
 - ii. A subcontractor of Contractor, as governed by 42 C.F.R. section 438.230. (42 C.F.R. § 438.610(c)(2).)
 - iii. A person with beneficial ownership of five percent or more of Contractor's equity. (42 C.F.R. § 438.610(c)(3).)
 - iv. A network provider or person with an employment, consulting, or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under this Agreement. (42 C.F.R. § 438.610(c)(4).)
- 4. Contractor, its contracted providers, and its subcontractors shall not employ or contract with, directly or indirectly, individuals or entities described in subsections E.1 and E.2 for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services (or the establishment of policies or provision of operational support for such services). (42 C.F.R. § 438.808(b)(3).)
 - 5. Contractor, its contracted providers, and its subcontractors shall not contract directly or indirectly with an individual convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act. (42 C.F.R. § 438.808(b)(2).)
 - 6. Contractor shall provide to County written disclosure of any prohibited affiliation identified by Contractor, its contracted providers, or its subcontractors. (42 C.F.R. § 438.608(c)(1).)

F. Disclosures.

- 1. **Disclosures of 5% or More Ownership Interest.** Contractor shall provide to County written disclosure of information on ownership and control of Contractor, its contracted providers, and its subcontractors (hereafter Disclosing Entity) as described in 42 C.F.R. section 455.104 and this subsection F.1 of this Section 5.1 (Federal and State Contract Compliance Requirements). Contractor shall provide disclosures to County on a form provided by County upon submitting the provider application, before entering into a provider agreement with County, before renewing a provider agreement with County, annually and upon request during the re-validation of enrollment process under 42 C.F.R. section 455.104, and within 35 days after any change in ownership of Disclosing Entity. The information included in the disclosures

shall be current as of the time submitted. The following information must be disclosed:

- i. The name and address of any person (individual or corporation) with an ownership or control interest in Disclosing Entity. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address.
 - ii. Date of birth and Social Security Number (in the case of an individual).
 - iii. Other tax identification number (in the case of a corporation) with an ownership or control interest in Disclosing Entity or in any subcontractor in which Disclosing Entity has a five percent or more interest.
 - iv. Whether the person (individual or corporation) with an ownership or control interest in Disclosing Entity is related to another person with ownership or control interest in Disclosing Entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which Disclosing Entity has a five percent or more interest is related to another person with ownership or control interest in Disclosing Entity as a spouse, parent, child, or sibling.
 - v. The name of any other disclosing entity in which an owner of Disclosing Entity has an ownership or control interest.
 - vi. The name, address, date of birth, and Social Security Number of any managing employee of Disclosing Entity.
- 2. Disclosures Related to Business Transactions.** Contractor shall submit the following disclosures and updated disclosures related to certain business transactions to County, the California Department of Health Care Services (DHCS), or the United States Department of Health and Human Services (HHS) within 35 days upon request. The following information must be disclosed:
- i. The ownership of any subcontractor with whom Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
 - ii. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request.

3. Disclosures Related to Persons Convicted of Crimes. Contractor certifies that it has submitted the following disclosures related to persons convicted of crimes to County before entering into this Agreement. Contractor shall submit the following disclosures to County or DHCS at any time upon request. The following information must be disclosed:

- i. The identity of any person who has an ownership or control interest in or is a managing employee of Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1) and (2).)
- ii. The identity of any person who is an agent of Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1) and (2).) For this purpose, the word “agent” has the meaning described in 42 C.F.R. section 455.101.

4. Remedies. If Contractor fails to comply with disclosure requirements, remedies available to County and DHCS include:

- i. Federal Financial Participation (FFP) is not available in expenditures for services furnished by Contractor that fail to comply with a request made by County, DHCS, or the Secretary of HHS under subsections F.1 and F.2 of this Section 5.1 (Federal and State Contract Compliance Requirements) or under 42 C.F.R. section 420.205 (Disclosure by providers and part B suppliers of business transaction information). FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to County, DHCS, or the Secretary of HHS and ending on the day before the date on which the information was supplied. (42 C.F.R. §§ 455.104(f), 455.105(c).)
- ii. Contractor shall reimburse those Medi-Cal funds received during any period for which material information was not reported, or reported falsely, to County or DHCS. (Welf. & Inst. Code, § 14043.3.)

G. Records, Audit, and Review.

- 1. Contractor shall maintain and preserve books and records and documents of any type whatsoever, whether physical or electronic, pertaining to Medi-Cal enrollees, Medi-Cal-related activities, or any aspect of services and activities performed, or determinations of amounts payable, under this Agreement including, but not limited to: member grievance and appeal records; the data, information, and documentation specified in (or that demonstrates compliance with) 42 C.F.R. sections 438.604, 438.606, 438.608, and 438.610;

working papers; reports; financial records and documents of account; member records; prescription files; and subcontracts (hereafter Records).

2. Contractor shall make available all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, electronic systems, or any employee pertaining to Medi-Cal enrollees, Medi-Cal-related activities, or any aspect of services and activities performed, or determinations of amounts payable, under this Agreement at any time for auditing, evaluation, inspection, examination, or copying by County, the California Department of Health Care Services (DHCS), the California Department of General Services, the California State Auditor, the United States Centers for Medicare and Medicaid Services (CMS), the United States Department of Health and Human Services Office of Inspector General (HHS Inspector General), the United States Comptroller General, or other authorized federal or state agencies, or their designees (hereafter Audit). The right to Audit includes, but is not limited to, the right to Audit if County, DHCS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk.
3. Both the requirement to maintain and preserve Records under subsection G.1 of this Section (Federal and State Contract Compliance Requirements) and the right to Audit under subsection G.2 shall exist for 10 years from the term end date of this Agreement or as required by subsections i through iii below, whichever is later:
 - i. Applicable statute,
 - ii. Any other provision of this Agreement, or
 - iii. If any litigation, claim, negotiation, audit, or other action pertaining to Medi-Cal enrollees, Medi-Cal-related activities, or any aspect of services and activities performed, or determinations of amounts payable, under this Agreement has been started before the expiration of the 10-year period, until completion of the action and resolution of all issues which arise from it.
4. Contractor shall include subsection G (Records, Audit, and Review) of this Section (Federal and State Contract Compliance Requirements) in all subcontracts to perform work under this Agreement.

H. Conflict of Interest.

1. Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. section 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Social Security Act (42 C.F.R. § 438.3(f)(2)) and the California Political Reform Act of 1974 (Gov. Code, § 81000 et seq.), Public Contract Code section 10365.5, and Government Code section 1090.
2. Contractor acknowledges and agrees that County and the California Department of Health Care Services (DHCS) intends to avoid any real or apparent conflict of interest on the part of Contractor, Contractor's subcontractor, or employees, officers, and directors of Contractor or subcontractor. Thus, County and DHCS reserve the right to determine, at their sole discretion, whether any information, assertion, or claim received from any source indicates the existence of a real or apparent conflict of interest, and if a conflict is found to exist, to require Contractor to submit additional information or a plan for resolving the conflict, subject to County and DHCS review and prior approval.
3. Conflicts of interest include:
 - i. An instance where Contractor or subcontractor, or any employee, officer, or director of Contractor or subcontractor, has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under this Agreement would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of this Agreement.
 - ii. An instance where Contractor's or subcontractor's employees, officers, or directors use their position for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties.
4. If County is or becomes aware of a known or suspected conflict of interest, County will notify Contractor of the known or suspected conflict, and Contractor will have five working days from the date of notification to provide complete information regarding the suspected conflict to County. County may, at its discretion, authorize an extension of the timeline indicated herein in writing. If a conflict of interest is determined to exist by County or DHCS and cannot be resolved to the satisfaction of County or DHCS, the conflict may be grounds for terminating this Agreement.

5. Contractor shall include subsection H (Conflict of Interest) of this Section (Federal and State Contract Compliance Requirements) in all subcontracts to perform work under this Agreement.

I. Nondiscrimination and Compliance (General Terms and Conditions 02/2025).

1. During the performance of this Agreement, Contractor and its subcontractors shall not deny this Agreement's benefits to any person on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status, nor shall they discriminate unlawfully against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status. Contractor shall ensure that the evaluation and treatment of employees and applicants for employment are free of such discrimination. Contractor and subcontractors shall comply with the provisions of the California Fair Employment and Housing Act (Gov. Code, § 12900 et seq.), the regulations promulgated thereunder (2 C.C.R. § 11000 et seq.), the provisions of article 9.5, chapter 1, part 1, division 3, title 2 of the Government Code (Gov. Code, §§ 11135–11139.5), and the regulations or standards adopted by the California Department of Health Care Services (DHCS) to implement such article. Contractor shall permit access by representatives of the California Civil Rights Department (CRD) and DHCS upon reasonable notice at any time during normal business hours, but in no case less than 24 hours' notice, to such of its books, records, accounts, and all other sources of information and its facilities as CRD or DHCS shall require to ascertain compliance with this provision. Contractor and subcontractors shall give written notice of their obligations under this provision to labor organizations with which they have a collective bargaining or other agreement. (See Cal. Code Regs., tit. 2, § 11105.)
2. Contractor shall include subsection I (Nondiscrimination and Compliance (GTC 02/2025) of this Section (Federal and State Contract Compliance Requirements) in all subcontracts to perform work under the Agreement.

J. Nondiscrimination and Compliance.

1. Consistent with the requirements of applicable federal law, such as 42 C.F.R. section 438.3(d)(3) and (4), and state law, Contractor shall not engage in any

unlawful discriminatory practices in the admission of members, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on any ground protected under federal or state law including sex, race, color, gender, gender identity, religion, marital status, national origin, ethnic group identification, ancestry, age, sexual orientation, medical condition, genetic information, or mental or physical handicap or disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(3)–(4); 45 C.F.R. § 92.2; Gov. Code, § 11135(a); Welf. & Inst. Code, § 14727(a)(3).)

2. Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), prohibiting exclusion, denial of benefits, and discrimination against qualified individuals with a disability in any federally assisted programs or activities, and shall comply with the implementing regulations in 45 C.F.R. parts 84 and 85, as applicable.
3. Contractor shall include subsection J (Nondiscrimination and Compliance) of this Section (Federal and State Contract Compliance Requirements) in all subcontracts to perform work under this Agreement.
4. Noncompliance with the nondiscrimination requirements in subsection J (Nondiscrimination and Compliance) of this Section (Federal and State Contract Compliance Requirements) shall constitute grounds for County or the California Department of Health Care Services to withhold payments under this Agreement.

K. Subcontract Requirements.

1. Contractor is hereby advised of its obligations pursuant to the following numbered provisions of Integrated Intergovernmental Agreement, Exhibit D (Special Terms and Conditions): Sections 1 Federal Equal Employment Opportunity Requirements; 2 Travel and Per Diem Reimbursement; 3 Procurement Rules; 4 Equipment Ownership/Inventory/Disposition; 5 Subcontract Requirements; 6 Income Restrictions; 7 Audit and Record Retention; 8 Site Inspection; 9 Federal Contract Funds; 11 Intellectual Property Rights; 12 Air or Water Pollution Requirements; 13 Prior Approval of Training Seminars, Workshops, or Conferences; 14 Confidentiality of Information; 15 Documents, Publications, and Written Reports; 18 Human Subjects Use Requirements; 19 Debarment and Suspension Certification; 20 Smoke-Free Workplace Certification; 21 Drug Free Workplace Act of 1988; 23 Payment Withhold; 26 Officials Not to Benefit; 27 Prohibited Use of State

Funds for Software; 34 Suspension or Stop Work Notification; 35 Public Communications; and 37 Compliance with Statutes and Regulations; and 38 Lobbying Restrictions and Disclosure Certification.

L. Federal Equal Employment Opportunity Requirements.

1. Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action will include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government or the California Department of Health Care Services (DHCS), setting forth the provisions of the Equal Opportunity clause, section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212). Such notices will state Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
2. Contractor will, in all solicitations or advancements for employees placed by or on behalf of Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
3. Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of the Contractor's

commitments under the provisions herein and will post copies of the notice in conspicuous places available to employees and applicants for employment.

4. Contractor will comply with all provisions of and furnish all information and reports required by section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212) and of Federal Executive Order No. 11246, as amended, including by Executive Order No. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by the regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
5. Contractor will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by the regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the United States Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the U.S. Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
6. In the event of Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be canceled, terminated, or suspended in whole or in part, and Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the U.S. Secretary of Labor, or as otherwise provided by law.
7. Contractor will include subsection L (Federal Equal Employment Opportunity Requirements) of this Section (Federal and State Contract Compliance

Requirements) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by the regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or section 503 of the Rehabilitation Act of 1973 (38 U.S.C. § 4212) or of the Vietnam Era Veteran's Readjustment Assistance Act so that such provisions will be binding upon each subcontractor or vendor. Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

M. Debarment and Suspension Certification.

1. Contractor agrees to comply with applicable federal suspension and debarment regulations including, but not limited to, 2 C.F.R. part 180 and 2 C.F.R. part 376.
2. Contractor certifies to the best of its knowledge and belief that it and its principals:
 - i. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
 - ii. Have not within a three-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) violation of federal or state antitrust statutes, or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any

other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

- iii. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in subsection 2.ii, subsection M (Debarment and Suspension Certification) of this Section (Federal and State Contract Compliance Requirements);
 - iv. Have not within a three-year period preceding this Agreement had one or more public transactions (federal, state, or local) terminated for cause or default; and
 - v. Have not within a three-year period preceding this Agreement engaged in any of the violations listed under 2 C.F.R. part 180, subpart C, as supplemented by 2 C.F.R. part 376.
3. Contractor shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction unless authorized by the California Department of Health Care Services (DHCS).
 4. The terms and definitions herein have the meanings set out in 2 C.F.R. part 180, as supplemented by 2 C.F.R. part 376.
 5. Contractor will include subsection M (Debarment and Suspension Certification) of this Section (Federal and State Contract Compliance Requirements) in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
 6. If Contractor knowingly violates this certification, in addition to other remedies available to the federal government, County or DHCS may terminate this Agreement for cause or default.

N. Uniform Administrative Requirements, Cost Principles, And Audit Requirements For Federal Awards.

1. Contractor shall comply with the requirements of 2 Code of Federal Regulations (C.F.R.) parts 200 and 300, which are incorporated herein by reference.
2. Contractor shall include these requirements in all subcontracts to perform work under this Agreement.

O. Mandatory Disclosures.

1. Contractor must promptly disclose whenever, in connection with this Agreement (including any activities or subcontracts thereunder), it has credible evidence of the commission of a violation of federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in title 18 of the United States Code (U.S.C.) or a violation of the civil False Claims Act (31 U.S.C. §§ 3729–3733). The disclosure must be made in writing to County, DHCS, the United States Centers for Medicare and Medicaid Services, and the United States Department of Health and Human Services Office of Inspector General. Contractor is also required to report matters related to County, state, or federal agency's integrity and performance in accordance with Appendix XII of 2 Code of Federal Regulations part 200. Failure to make required disclosures can result in any of the remedies described in 2 Code of Federal Regulations section 200.339 Remedies for noncompliance. (See also 2 C.F.R. part 180, 31 U.S.C. § 3321, and 41 U.S.C. § 2313.)
2. Contractor shall include these requirements in all subcontracts to perform work under this Agreement.
3. Contractor shall also comply with the disclosure provisions set forth below in Section S (Byrd Anti-Lobbying Amendment) and this EXHIBIT AA General Provisions to this Agreement.

P. Prohibition On Certain Telecommunications And Video Surveillance Services Or Equipment.

1. Contractor is prohibited from obligating or expending loan or grant funds to:
 - i. Procure or obtain covered telecommunications equipment or services;
 - ii. Extend or renew a contract to procure or obtain covered telecommunications equipment or services; or
 - iii. Enter into a contract (or extend or renew a contract) to procure or obtain covered telecommunications equipment or services.
2. As described in section 889 of Public Law 115-232 “covered telecommunications equipment or services” means any of the following:
 - i. Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

- ii. For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);
 - iii. Telecommunications or video surveillance services provided by such entities or using such equipment; or
 - iv. Telecommunications or video surveillance equipment or services produced or provided by an entity that the United States Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.
- 3. For the purposes of this section, “covered telecommunications equipment or services” also include systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system.
- 4. In implementing the prohibition under section 889 of Public Law 115-232, heads of executive agencies administering loan, grant, or subsidy programs must prioritize available funding and technical support to assist affected businesses, institutions, and organizations as is reasonably necessary for those affected entities to transition from covered telecommunications equipment or services, to procure replacement equipment or services, and to ensure that communications service to users and customers is sustained.
- 5. Contractor certifies that it will comply with the prohibition on covered telecommunications equipment and services in this section. Contractor and its subcontractors are not required to certify that funds will not be expended on covered telecommunications equipment or services beyond the certification provided upon accepting grant funding and those provided upon submitting payment requests and financial reports.
- 6. For additional information, see section 889 of Public Law 115-232 and 2 Code of Federal Regulations section 200.471.
- 7. Contractor shall include these requirements in all subcontracts to perform work under this Agreement.

Q. Domestic Preferences for Procurements.

1. Contractor should, to the greatest extent practicable and consistent with law, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States (including, but not limited to, iron, aluminum, steel, cement, and other manufactured products).
2. For purposes of this section:
 - i. “Produced in the United States” means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.
 - ii. “Manufactured products” means items and construction materials composed in whole or in part of nonferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.
3. Contractor shall include these requirements in all subcontracts to perform work under this Agreement.

R. Procurement of Recovered Materials.

1. Contractor shall comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976 as amended, 42 United States Code section 6962. The requirements of section 6002 include procuring only items designated in guidelines of the United States Environmental Protection Agency (EPA) at 40 Code of Federal Regulations part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds \$10,000 or the value of the quantity acquired during the preceding fiscal year exceeded \$10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.
2. Contractor should, to the greatest extent practicable and consistent with law, purchase, acquire, or use products and services that can be reused, refurbished, or recycled; contain recycled content, are biobased, or are energy and water efficient; and are sustainable. This may include purchasing compostable items and other products and services that reduce the use of single-use plastic products. See Executive Order 14057, section 101, Policy.

3. Contractor shall include these requirements in all subcontracts to perform work under this Agreement.

S. Byrd Anti-Lobbying Amendment. (Applicable to federally funded agreements in excess of \$100,000.)

1. Certification and Disclosure Requirements.

- i. Contractor must file a certification (in the form set forth in EXHIBIT D, Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that Contractor has not made and will not make any payment prohibited by subsection 2 (Prohibition) of this Section (Byrd Anti-Lobbying Amendment).
- ii. Contractor must file a disclosure (in the form set forth in EXHIBIT D, Attachment 2, entitled “Standard Form-LLL ‘Disclosure of Lobbying Activities’”) if Contractor has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant which would be prohibited under subsection 2 (Prohibition) of this Section (Byrd Anti-Lobbying Amendment) if paid for with appropriated funds.
- iii. Contractor must file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Contractor under subsection 1.ii of this Section (Byrd Anti-Lobbying Amendment). An event that materially affects the accuracy of the information reported includes:
 - a. A cumulative increase of \$25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;
 - b. A change in the person(s) or individual(s) influencing or attempting to influence a covered federal action; or
 - c. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.
- iv. Contractor shall require all lower tier subcontractors to certify and disclose to the next tier above.

v. All disclosure forms shall be forwarded from tier to tier until received by County.

2. **Prohibition.** Section 1352 of title 31 of the United States Code provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

3. Contractor shall include these requirements in all lower tier subcontracts exceeding \$100,000 to perform work under this Agreement.

T. Clean Air Act. (Applicable to federally funded agreements in excess of \$150,000.)

1. Contractor agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act, as amended, 42 United States Code section 7401 et seq.

2. Contractor agrees to report each violation to the California Environmental Protection Agency (CalEPA) and understands and agrees that CalEPA will, in turn, report each violation as required to assure notification to County, the federal agency which provided funds in support of this Agreement, and the appropriate Environmental Protection Agency Regional Office.

3. Contractor shall include these requirements in all subcontracts exceeding \$150,000 to perform work under this Agreement.

U. Federal Water Pollution Control Act. (Applicable to federally funded agreements in excess of \$150,000.)

1. Contractor agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 United States Code section 1251 et seq.

2. Contractor agrees to report each violation to CalEPA and understands and agrees that CalEPA will, in turn, report each violation as required to assure notification to County, the federal agency which provided funds in support of

this Agreement, and the appropriate Environmental Protection Agency Regional Office.

3. Contractor shall include these requirements in all subcontracts exceeding \$150,000 to perform work under this Agreement.

V. Alcohol And Drug Program.

1. Nullification of Drug Medi-Cal (DMC) Treatment Program Substance Use Disorder Services (if applicable).

- i. The parties agree that if the Contractor fails to comply with the provisions of Welfare and Institutions Code (W&I) Section 14124.24, all areas related to the DMC Treatment Program substance use disorder services shall be null and void and severed from the remainder of this Agreement.
- ii. In the event the Drug Medi-Cal Treatment Program Services component of this Agreement becomes null and void, an updated Exhibit B-1 will take effect reflecting the removal of federal Medicaid funds and DMC State General Funds from this Agreement. All other requirements and conditions of this Agreement will remain in effect until amended or terminated.

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

3. **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 (Heath & Safety Code § 11999-11999.3). By signing this Contract, Contractor agrees that it shall enforce, and shall require its subcontractors and contracted providers to enforce, these requirements.

4. **Noncompliance with Reporting Requirements.** Contractor agrees that DHCS, through County, has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Agreement and as identified in Document 1F(a) to the Intergovernmental Agreement (Reporting Requirement Matrix for Counties).

5. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances.

- i. 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).
- ii. Contractor is advised of its, and shall advise all subcontractors of their, obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 C.F.R. Part 1001.

6. Health Insurance Portability and Accountability Act (HIPAA) of 1996. If any of the work performed under this Agreement is subject to HIPAA, then Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit F of the Intergovernmental Agreement Contract Number 24-40145, the State, County, and Contractor shall cooperate to assure mutual agreement as to those transactions between them, to which this provision applies. Refer to Intergovernmental Agreement Exhibit F for additional information.

i. Trading Partner Requirements.

- a. **No Changes.** County and Contractor hereby agree that for the personal health information (Information), it will not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 C.F.R. Part 162.915 (a)).
- b. **No Additions.** County and Contractor hereby agree that for the Information, it will not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 C.F.R. Part 162.915 (b)).
- c. **No Unauthorized Uses.** County and Contractor hereby agree that for the Information, it will not use any code or data elements that either are marked “not used” in the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications. (45 C.F.R. Part 162.915 (c)).
- d. **No Changes to Meaning or Intent.** County and Contractor hereby agree that for the Information, it will not change the meaning or intent

of any of the HHS Transaction Standard's implementation specification. (45 C.F.R. Part 162.915 (d)).

- ii. Concurrence for Test Modifications to HHS Transaction Standards. County agrees and understands that there exists the possibility that the State or others may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, County agrees that it will participate in such test modifications.
- iii. Adequate Testing. County is responsible to adequately test all business rules appropriate to their types and specialties. If the County is acting as a clearinghouse for enrolled providers, County has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.
- iv. Deficiencies. County and Contractor agree to cure transactions errors or deficiencies identified by the DHCS, and transactions errors or deficiencies identified by an enrolled provider if the County is acting as a clearinghouse for that provider. When County is a clearinghouse, County agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.
- v. Code Set Retention. Both Parties understand and agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer.
- vi. Data Transmission Log. Both Parties shall establish and maintain a Data Transmission Log, which shall record any and all Data Transmission taking place between the Parties during the term of this Agreement. Each Party will take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

7. Privacy and Security of Other Information Not Subject to HIPAA. In addition to the HIPAA, Contractor shall comply with Exhibit F to the Intergovernmental

Agreement, Contract Number 24-40145, with respect to personal information and personally identifiable information under the California Information Practices Act, Cal. Civil Code Sections 1798 et seq., and Title 42 C.F.R., Chapter I, Subchapter A, Part 2.

- 8. 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, C.C.R., Division 4, Chapter 8.
- 9. 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 and comply with 42 C.F.R. 438.206(c)(2).
- 10. Trafficking Victims Protection Act of 2000 (TVPA).** Contractor shall comply with the Trafficking Victims Protection Act of 2000 (22 U.S.C. Section 7104(g), as amended by Section 1702 of Pub.L. 112-239). The County has the authority to terminate the Agreement without penalty within 30 days or to take any other remedial action authorized under 22 U.S.C. Section 7104b(c), if the Contractor: (a) Engages in severe forms of trafficking in persons during the period of time that the Agreement is in effect; (b) Procures a commercial sex act during the period of time that the Agreement is in effect; or (c) Uses forced labor in the performance of the Agreement or subcontracts under the Agreement, in accordance with TVPA of 2000 and in accordance with *Department Policy #12.002 Trafficking Victims Protection Act of 2000* found at: [County of Santa Barbara Behavioral Wellness Department Policy #12.002 Trafficking Victims Protection Act of 2000](#). Contractor must inform County immediately of any information Contractor receives from any source alleging a violation of a prohibition in this paragraph. For full text of the award term, go to: [22 USC 7104: Prevention of Trafficking](#).
- 11. Adolescent Substance Use Disorder Best Practices Guide.** Contractor will follow the California Adolescent Substance Use Disorder Best Practices Guide available at [DHCS California Adolescent Substance Use Disorder Best Practices Guide](#) and incorporated by this reference, in developing and implementing adolescent treatment programs funded under this Agreement, until such time as new adolescent guidelines are established and adopted. No

formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

12. Nondiscrimination in Employment and Services. By signing this Agreement, Contractor certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Contractor will not unlawfully discriminate against any person.

13. Federal Law Requirements. Contractor shall comply with all applicable Federal laws including:

- i. 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.
- ii. Title IX of the Education Amendments of 1972 (regarding education and programs and activities), if applicable.
- iii. 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.
- iv. Age Discrimination Act of 1975 (45 C.F.R. Part 90), as amended (42 USC Sections 6101 - 6107), which prohibits discrimination on the basis of age.
- v. Age Discrimination in Employment Act (29 C.F.R. Part 1625).
- vi. Title I of the Americans with Disabilities Act (29 C.F.R. Part 1630) prohibiting discrimination against the disabled in employment.
- vii. Americans with Disabilities Act (28 C.F.R. Part 35) prohibiting discrimination against the disabled by public entities.
- viii. Title III of the Americans with Disabilities Act (28 C.F.R. Part 36) regarding access.
- ix. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
- x. Executive Order 11246 (42 USC § 2000(e) et seq. and 41 C.F.R. Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than \$10,000 funded by federal financial assistance.

- xi. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
- xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
- xiii. Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, Subparts A – E).
- xiv. 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.
- xv. Section 1557 of the Patient Protection and Affordable Care Act.
- xvi. Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. Section 438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent Contractors.

14. State Law Requirements. Contractor shall comply with all applicable State laws including:

- i. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (2 C.C.R. § 10000 et seq.).
- ii. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- iii. Title 9, Division 4, Chapter 8 of the C.C.R., commencing with Section 10800.
- iv. No state or federal funds shall be used by the Contractor for sectarian worship, instruction, or proselytization. No state funds shall be used by the Contractor or to provide direct, immediate, or substantial support to any religious activity.
- v. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for the State to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

15. Investigations and Confidentiality of Administrative Actions.

- i. Contractor acknowledges that if it 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 WIC 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. DHCS may also issue a Payment Suspension to a provider pursuant to WIC Section 14107.11 and C.F.R., Title 42, Section 455.23. The County is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.

- ii. County and DHCS have entered a Confidentiality Agreement that permits DHCS to communicate with County concerning subcontracted providers that are subject to administrative sanctions.

16. Additional Federal and State Requirements. This Contract is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments that affect the provisions, terms, or funding of this Agreement in any manner.

17. Regulations and Guidelines. Contractor shall comply with the following regulations and guidelines:

- i. Title 21, C.F.R. Part 1300 et seq., Title 42, C.F.R., Part 8;
- ii. Drug Medi-Cal Certification Standards for Substance Abuse Clinics;
- iii. Title 22, C.C.R., Sections 51341.1, and 51490.1;
- iv. Standards for Drug Treatment Programs (October 21, 1981);
- v. Title 9, C.C.R., Division 4, Chapter 4, Subchapter 1, Section 10000 et seq.;
- vi. Title 22, C.C.R., Section 51000 et seq;
- vii. HSC, Division 10.5, commencing with Section 11760;
- viii. Title 9, C.C.R., Division 4, Chapter 8, commencing with Section 13000;
- ix. Government Code Section 16367.8;
- x. Title 42, C.F.R., Sections 8.1 through 8.6;
- xi. Title 21, C.F.R., Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and
- xii. State Administrative Manual (SAM), Chapter 7200 (Governmental Accounting and Reporting).

In the event of conflicts, the provisions of Title 22 of the California Code of Regulations shall control if they are more stringent.

18. Control Requirements.

- i. Contractor shall establish written policies and procedures consistent with these requirements:
 - a. HSC, Division 10.5, commencing with Section 11760.
 - b. Title 9, C.C.R., Division 4, Chapter 8, commencing with Section 13000.
 - c. Government Code Section 16367.8.
 - d. Title 42, C.F.R., Sections 8.1 through 8.6.
 - e. Title 21, C.F.R., Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances.
 - f. State Administrative Manual (SAM), Chapter 7200 (Governmental Accounting and Reporting).
- ii. Contractor shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors, if any, are also familiar with such requirements.

19. State Revocation. The DHCS may revoke this Agreement, in whole or in part, or may revoke the activities or obligations delegated to Contractor by the County, or pursue other remedies permitted by State or Federal law, if DHCS determines that Contractor has not performed satisfactorily. In such event, this Agreement shall be terminated in accordance with the Standard Terms and Conditions paragraph regarding Termination.

20. Participation in the County Behavioral Health Director's Association of California.

- i. County's AOD Program Administrator shall participate and represent the County in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.
- ii. County's AOD Program Administrator shall attend any special meetings called by the Director of DHCS.

EXHIBIT AA – AA1 ATTACHMENT 1 &2

CERTIFICATION REGARDING LOBBYING

ATTACHMENT 1
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The recipient certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned must complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" (Attachment 2) in accordance with its instructions.
3. The recipient must require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of \$100,000 or more, and that all subrecipients must certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification will be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

By signing or otherwise accepting the Agreement, the recipient certifies and files this Attachment 1. **CERTIFICATION REGARDING LOBBYING**, as required by Section 1352, Title 31, U.S.C., unless the conditions stated in paragraph 2 above exist. In such case, the awardee/contractor must complete and sign Attachment 2.

Casa Pacifica Center for Children and Families

Shawna Morris

Name of Contractor

Printed Name of Person Signing for Contractor

Contract / Grant Number

6/10/2026

Signed by:

Shawna Morris

ADEF68E32CD84D8...

Signature of Person Signing for Contractor

Chief Executive Officer

Date

Title

After execution by or on behalf of Contractor, please return to:

Santa Barbara County Department of Behavioral Wellness Contracts Division
 Attn: Contracts Manager
 429 N. San Antonio Rd.
 Santa Barbara, CA 93110

County reserves the right to notify the contractor in writing of an alternate submission address.

ATTACHMENT 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB (0348-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:		2. Status of Federal Action:		3. Report Type:	
☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance		☐ a. bid/offer/application ☐ b. initial award ☐ c. post-award		☐ a. initial filing ☐ b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.	
4. Name and Address of Reporting Entity:			5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:		
☐ Prime ☐ Subawardee Tier, if known:					
Congressional District, If known:			Congressional District, If known:		
6. Federal Department/Agency			7. Federal Program Name/Description:		
			CDFA Number, if applicable:		
8. Federal Action Number, if known:			9. Award Amount, if known:		
10.a. Name and Address of Lobbying Registrant (If individual, last name, first name, MI):			b. Individuals Performing Services (including address if different from 10a. (Last name, First name, MI):		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than \$100,000 for each such failure.					
Signature:					
Print Name:					
Title:					
Telephone Number:					
Date:					
Federal Use Only				Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grant.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

- a.** (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.
 - b.** (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
- 10.** The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

EXHIBIT B(S)

FINANCIAL PROVISIONS

ADP AND MHS

**EXHIBIT B ADP/MHS
GENERAL FINANCIAL PROVISIONS**

(Applicable to programs described in Exhibit A-1 – A5)

(With attached *Exhibit B-1* MHS (Schedule of Rates and Contract Maximum), *Exhibit B-2* (Entity Budget by Program), and *Exhibit B-3* (Entity Rates and Codes by Service Type)

This Agreement provides for reimbursement for services up to the Maximum Contract Amount, reflected in Section II below and Exhibit B-1(s). For Medi-Cal and all other services provided under this Agreement, Contractor shall comply with all applicable requirements necessary for reimbursement in accordance with Welfare and Institutions Code (WIC) §§ 14705-14711, the Intergovernmental Agreement, and other applicable Federal, State and local laws, regulations, rules, manuals, policies, guidelines and directives.

1. PAYMENT FOR SERVICES.

A. Alcohol and Drug Programs. (RESERVED)

B. Mental Health Services.

- 1. Medi-Cal Programs.** For Medi-Cal specialty mental health programs, the County reimburses all eligible providers on a fee-for-service basis pursuant to a fee schedule. Eligible providers claim reimbursement for services using appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes. Exhibit B-3 MHS contains a rate for each Eligible Practitioner or Service Type and the relevant CPT®/HCPCS code.
- 2. Non-Medi-Cal Programs.** For Non-Medi-Cal programs and costs, Contractor shall be compensated on a cost reimbursement basis, subject to the limitations described in this Agreement and all exhibits hereto, for deliverables as established in the Exhibit B(s) based on satisfactory performance of the services described in Exhibit A(s).
- 3. Medi-Cal Billable Services.** The services provided by Contractor as described in Exhibit A(s) that are covered by the Medi-Cal program will be paid based on the satisfactory performance of services and the fee schedule(s) as incorporated in Exhibit B-1 MHS of this Agreement.

C. Limitations on Use of Funds Received Pursuant to this Agreement. Contractor shall use the funds provided by County exclusively for the purposes of performing the services described in Exhibit A(s) to this Agreement. For Contractor Programs that are funded with Federal funds other than fee-for-service Medi-Cal, expenses shall comply with the requirements established in OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (45

C.F.R. Part 75), and all other applicable regulations. Violation of this provision or use of County funds for purposes other than those described in the Exhibit A(s) shall constitute a material breach of this Agreement.

D. Funding Sources.

1. The Behavioral Wellness Director or designee may reallocate between funding sources with discretion, including to utilize and maximize any additional funding or FFP provided by local, State, or Federal law, regulation, policy, procedure, or program. Reallocation of funding sources does not alter the Maximum Contract Amount and does not require an amendment to this Agreement.

E. Member Liability for Payment.

1. Alcohol and Drug Program. (RESERVED)

2. Mental Health.

- i. Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the member or persons acting on behalf of the member for any specialty mental health or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments. (Cal. Code Regs., tit. 9, § 1810.365 (a).)
- ii. Contractor shall not hold beneficiaries liable for debts in the event that County becomes insolvent; for costs of covered services for which the State does not pay County; for costs of covered services for which the State or County does not pay to Contractor; for costs of covered services provided under a contract, referral or other arrangement rather than from the County; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a member. (42 C.F.R. § 438.106 and Cal. Code Regs. tit 9, § 1810.365(c).)
- iii. Contractor shall not bill members for covered services under a contractual, referral, or other arrangement with Contractor in excess of the amount that would be owed by the member if Contractor had directly provided the services. (42 U.S.C. § 1396u-2(b)(6)(C).)

F. Hold Harmless.

1. Contractor acknowledges and agrees DHCS assumes no responsibility for the payment of Contractor for services performed pursuant to this Agreement.

County accepts sole responsibility for the payment of Contractor for services performed pursuant to this Agreement.

2. Contractor agrees to hold harmless both the State and members in the event County cannot or does not pay for services performed by Contractor pursuant to this Agreement.

2. **MAXIMUM CONTRACT AMOUNT.** The contract maximum shall consist of County, State, and/or Federal funds as shown in Exhibit B-1(s) and subject to the provisions in Section 1 (Payment for Services). Notwithstanding any other provision of this Agreement, in no event shall County pay Contractor more than this Maximum Contract Amount for Contractor's performance hereunder without a properly executed amendment.

- A. The Maximum Contract Amount of this Agreement shall not exceed \$5,602,530 inclusive of:

1. **Alcohol Drug Program Services.** (RESERVED)

2. **Mental Health Services:**

- i. \$5,602,530 in Mental Health funding, inclusive of \$2,801,265 for FY 26-27 and \$2,801,625 for FY 27-28.

3. **OPERATING BUDGET AND FEE FOR SERVICE RATES.**

- A. **Alcohol and Drug Program.** (RESERVED)

- B. **Mental Health Services.**

1. **Fee-For-Service Rates.** For Medi-Cal services, County agrees to reimburse Contractor at a Negotiated Fee-For-Service rate (the "Negotiated Fee") during the term of this Agreement as specified in Exhibit B-1 and B-3 MHS. Specialty mental health services provided to Non-Medi-Cal members will be paid at the same rates. Reimbursement or payment under this provision is subject to the maximum amount specified in the Exhibit B-1 MHS for Medi-Cal and Non-Medi-Cal specialty mental health services.

2. Notwithstanding the foregoing, and at any time during the term of the Agreement, the Director of the Department of Behavioral Wellness or designee, in his or her sole discretion, may incorporate new codes, make fee-for-service rate changes to the Exhibit B-1 and B-3 MHS issued by the California Department of Health Care for County's operational reasons. Reimbursement remains subject to the contract maximum amount specified in the Exhibit B-1 and Exhibits B-3.

3. Additionally, the Behavioral Wellness Director or designee, in his or her sole discretion, may make rate changes to or otherwise update Exhibit B-1 and B-3 MHS for multi-year contracts annually. Any changes to Exhibit B-1 and B-3 MHS shall not alter the Maximum Contract Amount and shall not require an amendment to this Agreement but shall be in writing.

C. Operating Budget. For Non Medi-Cal Programs, Contractor shall provide County with an Operating Budget on a format acceptable to, or provided by County, based on costs of net of revenues as described in this Exhibit B-MHS, Section 5 (Accounting for Revenues). The approved Operating Budget shall be attached to this Agreement as Exhibit B2. County may disallow any expenses in excess of the adopted operating budget. Contractor shall request, in advance, approval from County for any budgetary changes. Indirect costs are limited to 15% of direct costs for each program and must be allocated in accordance with a cost allocation plan that adheres with OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Pursuant to Behavioral Health Information Notice No: 24-047, Subrecipients of federal awards have the option to elect an indirect cost rate limited to either 15% of direct costs, federally negotiated indirect cost rate.

4. BHSA MEMBER FLEXIBLE SUPPORT FUNDS. (RESERVED)

5. ACCOUNTING FOR REVENUES.

A. Accounting for Revenues. Contractor shall comply with all County, State, and Federal requirements and procedures, including, but not limited to, those described in California Welfare and Institutions Code (WIC) Sections 5709, 5710 and 14710, relating to the:

1. Determination and collection of patient/member fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP);
2. Eligibility of patients/members for Medi-Cal, Medicare, private insurance, or other third party revenue, and
3. Collection, reporting and deduction of all patient/member and other revenue for patients/members receiving services hereunder.
4. For Non-Medi-Cal programs, grants, and any other revenue, interest and return resulting from services/activities and/or funds paid by County to Contractor shall also be accounted for in the Operating Budget.

B. Internal Procedures.

1. Contractor shall maintain internal financial controls which adequately ensure proper billing and collection procedures. Contractor shall pursue payment from all potential sources in sequential order, with Medi-Cal as payor of last resort. All fees paid by or on behalf of patients/members receiving services under this Agreement shall be utilized by Contractor only for the delivery of service units specified in the Exhibit A(s) to this Agreement.

2. **ADP. (RESERVED).**

6. REALLOCATION OF PROGRAM FUNDING.

- A. Funding is limited by program to the amount specified in Exhibit B-1-ADP and/or MHS. Contractor cannot move funding between programs without explicit approval by Behavioral Wellness Director or designee. Contractor shall make written application to Behavioral Wellness Director or designee, in advance and no later than April 1 of each Fiscal Year, to reallocate funds as outlined in Exhibit B-1, ADP and/or MHS between programs, for the purpose of meeting specific program needs or for providing continuity of care to its members. Contractor's application shall include a narrative specifying the purpose of the request, the amount of said funds to be reallocated, and the sustaining impact of the reallocation as may be applicable to future years. The Behavioral Wellness Director's or designee decision of whether to allow the reallocation of funds shall be in writing to Contractor prior to implementation by Contractor. The Behavioral Wellness Director or designee also reserves the right to reallocate between programs in the year-end settlement and will notify Contractor of any reallocation during the settlement process.

7. BILLING AND PAYMENT PROCEDURES AND LIMITATIONS.

A. Submission of Claims and Invoices.

1. **Alcohol and Drug Program. (RESERVED)**

2. **Mental Health Programs.**

- i. Submission of Claims for Medi-Cal Services. Services are to be entered into SmartCare based on timeframes prescribed in the Behavioral Wellness Clinical Documentation Manual. Late service data and claims may only be submitted in accordance with State and federal regulations. Behavioral Wellness shall provide to Contractor a report that: i) summarizes the Medi-Cal services approved to be claimed for the month, multiplied by the negotiated fee in effect at the time of service, ii) states the amount owed by County, and iii) includes the Agreement number.

- a. Contractor agrees that it shall be solely liable and responsible for all data and information submitted to the County and submitted by the County to the State on behalf of Contractor.
- b. If any services in the monthly Medi-Cal claim for the Contractor are denied by DHCS then these will be deducted from the subsequent monthly claim at the same value for which they were originally claimed. In the event that the State denies payment for services provided under this contract and such denial is later determined to be the result of inappropriate adjudication by the State, the County reserves the right to issue a credit to the Contractor for the denied services at the rates identified in Exhibit B-1 and B-2 MHS.

ii. Submission of Claims for Medicare Services.

- a. **Provider Enrollment.** Contractors that provide service to members that are eligible for both Medicare and Medi-Cal (AKA Medi-Medi) shall have Medicare eligible practitioner types enrolled in the Medicare program. The following are Medicare eligible licensed practitioners that provide service to County programs in this Agreement and must be enrolled in the Medicare program: Marriage and Family Therapist, Clinical Psychologist, Clinical Social Worker, Professional Clinical Counselor, Nurse Practitioner, Physician Assistant, and Medical Doctor. If any of the Contractor's eligible licensed practitioners have submitted a Medicare "Opt-Out" affidavit and are therefore opted-out of Medicare, these practitioners' services cannot be billed to Medicare and are not billable to Medi-Cal. *Opted-Out Medicare eligible practitioners are therefore ineligible service providers for Medi-Medi members.*
- b. **Medi-Medi.** The County won't assume financial responsibility or reimburse for services provided to Medi-Medi members by ineligible service providers due to opting out of Medicare.
- c. **Member Medicare Eligibility.** Contractor is responsible for identifying Medicare as a payor in the SmartCare EHR system. County only assumes financial responsibility for members that are dual eligible for Medicare and Medi-Cal. Services provided to members who have only Medicare, but not Medi-Cal are not eligible for reimbursement under this Agreement.

- d. Claims Adjudication.** For Medi-Medi member services, Contractor has the option to claim services to the Medicare fiscal intermediary directly or have the County process dual eligible claims on their behalf. If Contractor chooses to bill Medicare directly, Contractor is solely responsible to ensure proper Medicare registration and maintenance of such. Contractor shall notify Behavioral Wellness Fiscal within 30 days of the beginning of the contract term whether they want County to bill Medicare on their behalf. If the Contractor opts to bill the Medicare fiscal intermediary directly then they shall provide the County with Medicare claim(s) adjudication data which would allow the County to submit a crossover claim to the State Department of Health Care Services for the Medi-Cal adjudication and payment. If Contractor opts to bill Medicare directly then the claims adjudication data would be due monthly to Behavioral Wellness within 15 days following the close of each month.
- e. Submission of Claims for Medicare Services.** For Medi-Medi member services, services are to be entered into the SmartCare EHR system based on timeframes prescribed in the Behavioral Wellness Clinical Documentation Manual. Late service data and claims may only be submitted in accordance with State and federal regulations. Contractor agrees that it shall be solely liable and responsible for all data and information submitted to the County and submitted by the County to the State on behalf of Contractor.
- f. Claims Processing and Payment.** Services provided to members who are eligible for Medicare and Medi-Cal (Medi-Medi) will be claimed based on the guidelines outlined in the DHCS Billing Manual and Centers for Medicare & Medicaid Services (CMS) guidance. Contractor will be reimbursed for dual eligible members at the Medi-Cal fee-for-service rates in the Exhibit B-3 consistent with the payment terms for Medi-Cal approved services. The Medicare payment received by the County will be reported to DHCS within the subsequent Medi-Cal claim, thereby reducing the charge to Medi-Cal by the paid Medicare amount. County will issue a single payment for the service, at the fee-for-service rate in Exhibit B-2. Alternatively, if Contractor bills Medicare directly, then the Medicare payment received by the contractor must be offset from the fee-for-service rates paid by the County or remitted to the County. Services for members

with Medicare coverage only (not Medi-Medi) shall not be entered into SmartCare EHR, nor processed or paid by County. The fee schedule in Exhibit B-3 is therefore not applicable for Medicare only members. The Contractor is therefore solely responsible to follow all CMS regulations and provisions that govern Medicare member deductibles, co-pays and payments for services.

- iii. Submission of Claims for Non Medi-Cal Programs. Contractor shall submit a written invoice within 15 calendar days of the end of the month in which non-Medi-Cal services are delivered that: i) depicts the actual costs of providing the services less any applicable revenues, ii) states the amount owed by County, and iii) includes the Agreement number and signature of Contractor's authorized representative. Invoices shall be delivered to the designated representative or address described in Section 7.A.1.i (Submission of Claims for Medi-Cal Services) of this Exhibit B ADP/MHS. Actual cost is the actual amount paid or incurred, including direct labor and costs supported by financial statements, time records, invoices, and receipts.

B. Timing of Payment. The Program Contract Maximums specified in Exhibit B-1-MHS and this Exhibit B ADP/MHS are intended to cover services during the entire term of the Agreement, unless otherwise specified in the Exhibit A(s) to this Agreement (such as time-limited or services tied to the school year). Under no circumstances shall Contractor cease services prior to June 30 due to an accelerated draw down of funds earlier in the Fiscal Year. Failure to provide services during the entire term of the Agreement may be considered a breach of contract and subject to the Termination provisions specified in the Agreement.

- 1. The Behavioral Wellness Director or designee shall review the monthly claim(s) and invoices to confirm accuracy of the data submitted. County shall make payment for approved Medi-Cal claims within 30 calendar days of the generation of said claim(s) by County subject to the contractual limitations set forth in this Agreement and all exhibits hereto. Non-Medi-Cal programs will be paid within 30 days of the receipt of a complete invoice and all requested supporting documentation. Any fee-for-service Medi-Cal services that are not claimed during the fiscal year and require corrections and/or rebilling will be paid after Medi-Cal claiming for the period has concluded, which may be up to 12 months following the end of the fiscal year.

C. Monthly Financial Statements. For Non-Medi-Cal programs and costs, within 15 calendar days of the end of the month in which services are delivered, Contractor

shall submit monthly financial statements reflecting the previous month's and cumulative year to date direct and indirect costs and other applicable revenues for Contractor's programs described in the Exhibit A(s).

D. Withholding of Payment for Non-submission of Service Data and Other

Information. If any required service data, invoice, financial statement or report is not submitted by Contractor to County within the time limits described in this Agreement or if any such information is incomplete, incorrect, or is not completed in accordance with the requirements of this Agreement, then payment shall be withheld until County is in receipt of complete and correct data and such data has been reviewed and approved by Behavioral Wellness Director or designee. Behavioral Wellness Director or designee shall review such submitted service data within 60 calendar days of receipt.

E. Withholding of Payment for Unsatisfactory Clinical Documentation.

Behavioral Wellness Director or designee shall have the option to deny payment for services when documentation of clinical services does not meet minimum Federal, State and County written standards. County may also deny payment for services that are provided without a current member service plan when applicable authorities require a plan to be in place.

F. Claims Submission Restrictions.

1. Alcohol and Drug Program - Billing Limit for Drug Medi-Cal Services.
(RESERVED)

2. Mental Health 12-Month Billing Limit. Unless otherwise determined by State or federal regulations (e.g. Medi-Medi cross-over), all original (or initial) claims for eligible individual persons under this Agreement must be received by County within 12 months from the month of service to avoid denial for late billing.

3. No Payment for Services Provided Following Expiration/ Termination of Agreement. Contractor shall have no claim against County for payment of any funds or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment, it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provision shall survive the expiration or other termination of this Agreement.

G. Claims Certification and Program Integrity.

1. Contractor shall certify that all services entered by Contractor into County's EHR for any payor sources covered by this Agreement are true and accurate to the best of Contractor's knowledge.

H. Overpayments. If the Contractor discovers an overpayment, Contractor must notify the County in writing of the reason for the overpayment. Any overpayments of contractual amounts must be returned via direct payment within 30 calendar days to the County after the date on which the overpayment was identified. County may withhold amounts from future payments due to Contractor under this Agreement or any subsequent agreement if Contractor fails to make direct payment within the required timeframe.

8. REPORTS.

A. Audited Financial Reports. If the Contractor is reimbursed on a cost basis or receives any funding that is subject to audit requirements, whether under federal, state, grant, or other applicable funding guidelines, the Contractor shall obtain an annual independent financial statement audit. A copy of the audit report shall be submitted to the County within 30 calendar days of the Contractor's receipt of the final audit report.

B. If the Contractor voluntarily obtains an independent financial statement audit, even when not required by the terms of this Agreement or applicable funding guidelines, the Contractor shall also provide a copy of the final audit report to the County within 30 calendar days of receipt.

C. Single Audit Report. If Contractor is required to perform a single audit and/or program specific audit, per the requirements of OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements of Federal Awards, Contractor shall submit a copy of such single audit to County within 30 days of receipt. Subrecipients of federal awards must also submit a copy of their Single Audit Certification indicated whether they are subject to this requirement within 60 days after the end of the fiscal year.

D. Alcohol Drug Program. (RESERVED)

9. CONTINGENCY PAYMENT PROVISIONS.

A. Contingency Invoicing Plan (CIP). If the SmartCare EHR system causes delays or challenges to the extent that services cannot be claimed (and paid to the provider) within 45 days of the service month-end, the County will activate the Contingency Invoicing Plan (CIP) outlined below:

- 1. Notification and Submission.** Within 4 calendar days of determining that claiming will be delayed beyond the standard claiming window, the County will initiate the CIP.
- 2. Payment.** County shall issue payment based on the average value of Medi-Cal claims for the three-month period preceding initiation of the CIP. If sufficient claims data is not available, County shall instead issue payment equal to one-twelfth (1/12) of the Medi-Cal Patient Revenue contract allocation as specified in Exhibit B-1 MHS.
- 3. Resolution and Adjustment.** If the EHR delays or challenges are resolved during the invoice processing period, payment will be based on the services claimed in the system instead of the CIP protocol. Any payments made under the CIP will be reconciled back to actual claimed services once the system claiming functionality is fully validated, and claiming issues are resolved.
- 4. Monthly Determination.** The decision on whether to use CIP will be made by the Director of the Department of Behavioral Wellness or designee in his or her sole discretion on a monthly basis, considering the prevailing circumstances.

10. GENERAL FISCAL AUDIT REQUIREMENTS.

- A.** In addition to the requirements identified below, the Contractor and its subcontractors are required to meet the audit requirements as delineated in Exhibit C General Terms and Conditions and Exhibit D, Paragraph 7 of the Integrated Intergovernmental Agreement, the State Performance Agreement and Substance Use Block Grant.
- B.** All expenditures of county realignment funds, state and federal funds furnished to the Contractor and its subcontractors pursuant to this Agreement are subject to audit by DHCS. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of 45 C.F.R., Part 75, Subpart F and/or any independent Contractor audits or reviews. Objectives of such audits may include, but are not limited to, the following:
 - 1.** To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting.
 - 2.** To validate data reported by the Contractor for prospective contract negotiations.

3. To provide technical assistance in addressing current year activities and providing recommendations on internal controls, accounting procedures, financial records, and compliance with laws and regulations.
 4. To determine the cost of services, net of related patient and participant fees, third party payments, and other related revenues and funds.
 5. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and contract requirements.
 6. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Agreement objectives.
 - C. Unannounced visits to the Contractor and/or its subcontractors may be made at the discretion of DHCS.
 - D. The refusal of the Contractor or its subcontractors to permit access to and inspection of electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part constitutes an express and immediate material breach of this Agreement and will be sufficient basis to terminate the Agreement for cause or default.
 - E. Reports of audits conducted by DHCS shall reflect all findings, recommendations, adjustments and corrective actions as a result of its finding in any areas.
 - F. Contractor and its subcontractors, if any, shall include in any contract with an audit firm a clause to permit access by DHCS to the working papers of the external independent auditor, and require that copies of the working papers shall be made for DHCS at its request.
11. **SUBSTANCE USE BLOCK GRANT. (RESERVED)**
12. **AUDITS AND AUDIT APPEALS.**
- A. **Audit by Responsible Auditing Party.** At any time during the term of this Agreement or after the expiration or termination of this Agreement, in accordance with State and federal law, authorized representatives from the County, State or Federal governments (Responsible Auditing Party) may conduct an audit or site review of Contractor regarding the alcohol and drug program and/or mental health services/activities provided under this Agreement.
 - B. **Settlement.** Settlement of the audit findings will be conducted according to the Responsible Auditing Party's procedures in place. In the case of a State Medi-Cal audit, the State and County will perform a post-audit Drug Medi-Cal and/or Medi-

Cal settlement that is based on State audit findings. Such settlement will take place when the State initiates its settlement action which customarily is after the issuance of the audit report by the State and before the State's audit appeal process. However, if the Responsible Auditing Party stays its collection of any amounts due or payable because of the audit findings, County Behavioral Wellness will also stay its settlement of the same amounts due or payable until the Responsible Auditing Party initiates its settlement action with County Behavioral Wellness. If an audit adjustment is appealed then the County may, at its own discretion, notify Contractor but stay collection of amounts due until resolution of the State administrative appeals process.

- C. Invoice for Amounts Due.** County shall issue an invoice to Contractor for any amount due to the County after the Responsible Auditing Party issues an audit report. The amount on the County invoice is due by Contractor to County 30 calendar days from the date of the invoice.
- D. Appeal.** Contractor may appeal any such audit findings in accordance with the audit appeal process described in the Section 14171 of the WIC and 22 C.C.R. Section 51022.

13. LOSS OF FEDERAL AUTHORITY.

- A.** Should any part of the scope of work under this Contract relate to a state program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which Center for Medicare & Medicaid Services (CMS) has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. County will adjust payments that are specific to any state program or activity receiving FFP that is no longer authorized by law.
- B.** If Contractor works on a state program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work.
- C.** If County has paid Contractor in advance to work on a no-longer authorized state program or activity receiving FFP and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to the County.
- D.** If Contractor worked on a state program or activity receiving FFP prior to the date legal authority ended for that state program or activity, and County paid Contractor for that work, Contractor may keep the payment for that work even if the payment

was made after the date the state program or activity receiving FFP lost legal authority.

- E.** County will attempt to provide Contractor with timely notice of the loss of program authority, however, failure by County to provide notice of the loss of program authority shall not constitute a basis for Contractor to retain payments made for work performed following the date of the loss of program authority.

EXHIBIT B(S)

FINANCIAL PROVISIONS

MHS

EXHIBIT B-1 MHS SCHEDULE OF RATES AND CONTRACT MAXIMUM

(Applicable to program(s) described in Exhibit(s) A-1)

CONTRACTOR NAME:

Casa Pacifica

FISCAL YEAR: 2026-2028

Contracted Service	Service Type	Provider Group	Practitioner Type (4)	Hourly Rate (Avg. Direct Bill rate)
Medi-Cal Billable Services	Outpatient Services Fee-For-Service	Prescriber	Psychiatrist/ Contracted Psychiatrist	\$733.79
			Physician's Assistant	\$411.38
			Nurse Practitioner (& Cert Nurse Spec.)	\$456.12
		Non-Prescriber	Registered Nurse	\$372.57
			Licensed Vocational Nurse	\$195.72
			Licensed Psychiatric Technician	\$167.78
		Behavioral Health Provider	Psychologist/ Pre-licensed Psychologist	\$368.88
			LPHA / Assoc. LPHA/ LCSW	\$238.71
			Peer Specialist	\$188.59
			Rehabilitation Specialists & Other Qualified Providers	\$179.61
Medi-Cal Contract Allocation				\$73,530

Contracted Service	Service Type	Reimbursement Method
Non-Medi-Cal Billable Services	Outpatient Non-Medi-Cal Services (1)	Fee-For Service- 2% of Services
Non-Medi-Cal Contract Allocation		\$1,470
Total Contract Maximum		\$75,000

Contract Maximum by Program & Estimated Funding Sources				Total
	PROGRAM(S)			
Funding Sources (2)	STRTP			
Medi-Cal Patient Revenue (3)	\$ 73,530			\$ 73,530
Realignment Non-Medi-Cal Services	\$ 1,470			\$ 1,470
TOTAL CONTRACT PAYABLE FY 26-27	\$ 75,000	\$ -	\$ -	\$ 75,000
TOTAL CONTRACT PAYABLE FY 27-28	\$ 75,000	\$ -	\$ -	\$ 75,000
TOTAL CONTRACT PAYABLE FY 26-28	\$ 150,000	\$ -	\$ -	\$ 150,000

CONTRACTOR SIGNATURE:

FISCAL SERVICES SIGNATURE:

Signed by:

Shawna Morris

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Christie Boyer

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(1) Outpatient Non-Medi-Cal service allocation is intended to cover services provided to Non-Medi-Cal client services at the same Fee-For-Services rates as noted for Medi-Cal clients.

(2) The Director or designee may reallocate between funding sources at his/her discretion during the term of the contract, including to utilize and maximize any additional funding or FFP provided by local, State, or Federal law, regulation, policy, procedure, or program. Reallocation of funding sources does not alter the Maximum Contract Amount and does not require an amendment to the contract.

(3) Source of Medi-Cal match is State and Local Funds including but not limited to Realignment, BHSA, General Fund, Grants, Other Departmental Funds and SB 163.

(4) Refer to taxonomy codes in Exhibit B-3 for billable practitioner types within each provider group.

EXHIBIT B-1 MHS

SCHEDULE OF RATES AND CONTRACT MAXIMUM (CONTINUED)

(Applicable to program(s) described in Exhibit(s) A-2, A-4 and A-5)

CONTRACTOR NAME:

Casa Pacifica

FISCAL YEAR: 2026-2028

Contracted Service	Service Type	Provider Group	Practitioner Type (4)	Hourly Rate (Avg. Direct Bill rate)	Medi-Cal Contract Allocation
Medi-Cal Billable Services	Outpatient Services Fee-For- Service	Behavioral Health Provider	Psychologist/ Pre-licensed Psychologist	\$408.86	
			LPHA / Assoc. LPHA	\$264.58	
			Certified Peer Recovery Specialist	\$209.01	
			Rehabilitation Specialists & Other Qualified Providers	\$199.07	
					\$ 2,643,585
					\$ 2,643,585

Contracted Service	Service Type	Program(s)	Reimbursement Method	Non-Medi-Cal Contract Allocation
Non-Medi-Cal Billable Services	Outpatient Non-Medi-Cal Services (1)	2% of Medi-Cal for TBS	Fee-For-Service	\$ 38,680
	Outpatient Non-Medi-Cal Services (1)	Wraparound	Fee-For-Service (Paid by DSS)	\$ 44,000
				\$ 82,680
				\$ 2,726,265

Contract Maximum by Program & Estimated Funding Sources					Total
Funding Sources (2)	PROGRAM(S)				
	Therapeutic Behavioral Services (TBS)	Wraparound	FURS		
Medi-Cal Patient Revenue (3)	\$ 1,933,985	\$ 698,600	\$ 11,000	\$ 2,643,585	
Realignment Non-Medi-Cal Services	\$ 38,680	\$ -	\$ -	\$ 38,680	
Social Services Non-Medi-Cal Services	\$ -	\$ 44,000	\$ -	\$ 44,000	
TOTAL CONTRACT PAYABLE FY 26-27	\$ 1,972,665	\$ 742,600	\$ 11,000	\$ 2,726,265	
TOTAL CONTRACT PAYABLE FY 27-28	\$ 1,972,665	\$ 742,600	\$ 11,000	\$ 2,726,265	
TOTAL CONTRACT PAYABLE FY 26-28	\$ 3,945,330	\$ 1,485,200	\$ 22,000	\$ 5,452,530	

CONTRACTOR SIGNATURE:

Signed by:

Shawna Morris

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Docusign Inc. U.S.

FISCAL SERVICES SIGNATURE:

Signed by:

Christie Boyer

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Docusign Inc. U.S.

(1) Outpatient Non-Medi-Cal service allocation is intended to cover services provided to Non-Medi-Cal client services at the same Fee-For-Services rates as noted for Medi-Cal clients.

(2) The Director or designee may reallocate between funding sources at his/her discretion during the term of the contract, including to utilize and maximize any additional funding or FFP provided by local, State, or Federal law, regulation, policy, procedure, or program. Reallocation of funding sources does not alter the Maximum Contract Amount and does not require an amendment to the contract.

(3) Source of Medi-Cal match is State and Local Funds including but not limited to Realignment, BHSA, General Fund, Grants, Other Departmental Funds and SB 163.

(4) Refer to taxonomy codes in Exhibit B-3 for billable practitioner types within each provider group.

**EXHIBIT B-2 ADP/MHS
ENTITY BUDGET BY PROGRAM**

(RESERVED)

EXHIBIT B-3 MHS

ENTITY RATES AND CODES BY SERVICE TYPE

Behavioral Health Provider Fees (STRTP)

Provider type	Hourly Rate (Avg. Direct Bill rate)	Taxonomy Codes
Psychologist/ Pre-licensed Psychologist	\$368.88	102L, 103G, 103T
LPHA	\$238.71	1012, 101Y, 102X, 103K, 106H, 1714, 222Q, 225C, 2256
LCSW	\$238.71	106E, 1041
Peer Recovery Specialist	\$188.59	175T
Mental Health Rehabilitation Specialist	\$179.61	146D, 146L, 146M, 146N, 171M, 174H, 1837, 2217, 224Y, 224Z, 2254, 2258, 225A, 2260, 2263, 246Y, 246Z, 2470, 274K, 374T, 376K, 3902, 4053
Other Qualified Providers	\$179.61	171R, 172V, 3726, 373H, 374U, 376J

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
90785	Interactive Complexity	Supplemental Service Codes	Occurrence
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15
90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27
90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45
90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60
90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52
90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30
90845	Psychoanalysis, 15 Minutes	Therapy Codes	15
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50
90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15
90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Assessment Codes	15
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15
96105	Assessment of Aphasia, per Hour	Assessment Codes	60
96110	Developmental Screening, 15 Minutes	Assessment Codes	15
96112	Developmental Testing, First Hour	Assessment Codes	60
96113	Developmental Testing, Each Additional 30 Minutes	Assessment Codes	30
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60
96125	Standardized Cognitive Performance Testing, per Hour	Assessment Codes	60
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15
96130	Psychological Testing Evaluation, First Hour	Assessment Codes	60
96131	Psychological Testing Evaluation, Each Additional Hour	Assessment Codes	60
96132	Neuropsychological Testing Evaluation, First Hour	Assessment Codes	60
96133	Neuropsychological Testing Evaluation, Each Additional Hour	Assessment Codes	60
96136	Psychological or Neuropsychological Test Administration, First 30 Minutes	Assessment Codes	30
96137	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30
96146	Psychological or Neuropsychological Test Administration, 15 Minutes	Assessment Codes	15
96161	Caregiver Assessment Administration n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15
98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8
98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16
98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Plan Development Codes	60
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	Plan Development Codes	60
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes <i>(automatically added by SmartCare as appropriate)</i>	Add-on Code	15
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Peer Support Services Codes	15
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15
H0038	Self-help/peer services per 15 minutes	Peer Support Services Codes	15
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15

(1) The State Department of Health Care Services (DHCS) routinely updates CPT and HCPC codes. Refer to the DHCS County Claims Customer Services Library 'Specialty Mental Health Services Table' online at <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx> for a complete list of codes and associated billing requirements.

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Behavioral Health Provider Fees (TBS, Wraparound, FURS)

Provider type	Hourly Rate (Avg. Direct Bill rate)	Taxonomy Codes
Psychologist/ Pre-licensed Psychologist	\$408.86	102L, 103G, 103T
LPHA	\$264.58	1012, 101Y, 102X, 103K, 106H, 1714, 222Q, 225C, 2256
LCSW	\$264.58	106E, 1041
Peer Recovery Specialist	\$209.01	175T
Mental Health Rehab Specialist	\$199.07	146D, 146L, 146M, 146N, 171M, 174H, 1837, 2217, 224Y, 224Z, 2254, 2258, 225A, 2260, 2263, 246Y, 246Z, 2470, 274K, 374T, 376K, 3902, 4053
Other Qualified Providers	\$199.07	171R, 172V, 3726, 373H, 374U, 376J

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
90785	Interactive Complexity	Supplemental Service Codes	Occurrence
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15
90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27
90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45
90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60
90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52
90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30
90845	Psychoanalysis, 15 Minutes	Therapy Codes	15
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50
90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15
90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Assessment Codes	15
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15
96105	Assessment of Aphasia, per Hour	Assessment Codes	60
96110	Developmental Screening, 15 Minutes	Assessment Codes	15
96112	Developmental Testing, First Hour	Assessment Codes	60
96113	Developmental Testing, Each Additional 30 Minutes	Assessment Codes	30
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60
96125	Standardized Cognitive Performance Testing, per Hour	Assessment Codes	60
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15
96130	Psychological Testing Evaluation, First Hour	Assessment Codes	60
96131	Psychological Testing Evaluation, Each Additional Hour	Assessment Codes	60
96132	Neuropsychological Testing Evaluation, First Hour	Assessment Codes	60
96133	Neuropsychological Testing Evaluation, Each Additional Hour	Assessment Codes	60
96136	Psychological or Neuropsychological Test Administration, First 30 Minutes	Assessment Codes	30
96137	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
96146	Psychological or Neuropsychological Test Administration, 15 Minutes	Assessment Codes	15
96161	Caregiver Assessment Administration of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15
98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8
98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16
98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Plan Development Codes	60
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	Plan Development Codes	60
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60
G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes (<i>automatically added by SmartCare as appropriate</i>)	Add-on Code	15
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Peer Support Services Codes	15
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15
H0038	Self-help/peer services per 15 minutes	Peer Support Services Codes	15
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15

(1) The State Department of Health Care Services (DHCS) routinely updates CPT and HCPC codes. Refer to the DHCS County Claims Customer Services Library 'Specialty Mental Health Services Table' online at <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx> for a complete list of codes and associated billing requirements.

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Non-Prescriber Fees (STRTP)

Provider type	Hourly Rate (Avg. Direct Bill rate)	Taxonomy Codes
Registered Nurse	\$372.57	163W, 3675, 376G
Licensed Vocational Nurse	\$195.72	164W, 164X
Licensed Psychiatric Technician	\$167.78	106S, 167G, 3747

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
90785	Interactive Complexity	Supplemental Service Codes	Occurrence
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15
96110	Developmental Screening, 15 Minutes	Assessment Codes	15
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15
96138	Psychological or Neuropsychological Test Administration by Technician, First 30 Minutes	Assessment Codes	30
96139	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30
96161	Caregiver Assessment Administration of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15
96365	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis, 1-60 Minutes	Medication Support Codes	46
96366	Intravenous Infusion, for Therapy, Prophylaxis, Each Additional 30-60 Minutes past 96365	Medication Support Codes	45
96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Additional Sequential Infusion, 1-60 Minutes after 96365	Medication Support Codes	31
96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Concurrent Infusion, 15 Minutes	Medication Support Codes	15
96369	Subcutaneous Infusion for Therapy or Prophylaxis, Initial, 15-60 Minutes	Medication Support Codes	38
96370	Subcutaneous Infusion for Therapy or Prophylaxis, Each Additional 30-60 Minutes after 96369	Medication Support Codes	45
96371	Subcutaneous Infusion for Therapy or Prophylaxis, Additional Pump Set-Up, 15 Minutes	Medication Support Codes	15
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular, 15 Minutes. Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injection.	Medication Support Codes	15
96373	Therapeutic, Prophylactic, or Diagnostic Injection; Intra- Arterial, 15 Minutes	Medication Support Codes	15
96374	Therapeutic, Prophylactic, or Diagnostic Injection; Intravenous Push, Single or Initial Substance/Drug, 15 Minutes	Medication Support Codes	15
96375	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Push of a New Substance/Drug, 15 Minutes	Medication Support Codes	15
96376	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Drug Provided in a Facility; Has to be More than 30 Minutes after a Reported Push of the Same Drug, 1- 14 Minutes	Medication Support Codes	15
96377	Application of On- body Injector for Timed Subcutaneous Injection, 15 Minutes	Medication Support Codes	15
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Plan Development Codes	60

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	Plan Development Codes	60
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60
99605	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with New Patient with Assessment and Intervention, 15 Minutes	Medication Support Codes	15
99606	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with Established Patient with Assessment and Intervention, 15 Minutes	Medication Support Codes	15
99607	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with Patient with Assessment and Intervention, each Additional 15 Minutes beyond 99605 or 99606.	Medication Support Codes	15
G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes (<i>automatically added by SmartCare as appropriate</i>)	Add-on Code	15
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15
H0034	Medication Training and Support, per 15 Minutes	Medication Support Codes	15
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15
T1001	Nursing Assessment/Evaluation, 15 Minutes	Assessment Codes	15
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15

(1) The State Department of Health Care Services (DHCS) routinely updates CPT and HCPC codes. Refer to the DHCS County Claims Customer Services Library 'Specialty Mental Health Services Table' online at <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx> for a complete list of codes and associated billing requirements.

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Prescriber Fees (STRTP)

Provider type	Hourly Rate (Avg. Direct Bill rate)	Taxonomy Codes
Physician (including Psychiatrist)	\$733.79	202C, 202D, 202K, 204C, 204D, 204E, 204F, 204R, 207K, 207L, 207N, 207P, 207Q, 207R, 207S, 207T, 207U, 207V, 207W, 207X, 207Y, 207Z, 2080, 2081, 2082, 2083, 2084, 2085, 208C, 208D, 208G, 208M, 208U, 208V, 2098, 2086, 2087, 2088
Nurse Practitioner	\$456.12	363L
Physician's Assistant	\$411.38	363A

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
90785	Interactive Complexity	Supplemental Service Codes	Occurrence
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15
90792	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	Assessment Codes	15
90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27
90833	Psychotherapy, 30 Minutes with Patient when Performed with an Evaluation and Management Service	Therapy Codes	27
90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45
90836	Psychotherapy, 45 Minutes with Patient when Performed with an Evaluation and Management Service	Therapy Codes	45
90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60
90838	Psychotherapy, 60 Minutes with Patient when Performed with an Evaluation and Management Service	Therapy Codes	60
90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52
90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30
90845	Psychoanalysis, 15 Minutes	Therapy Codes	15
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50
90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15
90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Assessment Codes	15
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15
96161	Caregiver Assessment Administration of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15
96365	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis, 1-60 Minutes	Medication Support Codes	46
96366	Intravenous Infusion, for Therapy, Prophylaxis, Each Additional 30-60 Minutes past 96365	Medication Support Codes	45
96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Additional Sequential Infusion, 1-60 Minutes after 96365	Medication Support Codes	31
96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Concurrent Infusion, 15 Minutes	Medication Support Codes	15
96369	Subcutaneous Infusion for Therapy or Prophylaxis, Initial, 15-60 Minutes	Medication Support Codes	38
96370	Subcutaneous Infusion for Therapy or Prophylaxis, Each Additional 30-60 Minutes after 96369	Medication Support Codes	45
96371	Subcutaneous Infusion for Therapy or Prophylaxis, Additional Pump Set-Up, 15 Minutes	Medication Support Codes	15

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular, 15 Minutes. Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injection.	Medication Support Codes	15
96373	Therapeutic, Prophylactic, or Diagnostic Injection; Intra- Arterial, 15 Minutes	Medication Support Codes	15
96374	Therapeutic, Prophylactic, or Diagnostic Injection; Intravenous Push, Single or Initial Substance/Drug, 15 Minutes	Medication Support Codes	15
96375	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Push of a New Substance/Drug, 15 Minutes	Medication Support Codes	15
96376	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Drug Provided in a Facility; Has to be More than 30 Minutes after a Reported Push of the Same Drug, 1- 14 Minutes	Medication Support Codes	15
96377	Application of On- body Injector for Timed Subcutaneous Injection, 15 Minutes	Medication Support Codes	15
98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8
98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16
98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26
99202	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	Medication Support Codes	22
99203	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	Medication Support Codes	37
99204	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	Medication Support Codes	52
99205	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	Medication Support Codes	67
99212	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	Medication Support Codes	15
99213	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	Medication Support Codes	25
99214	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	Medication Support Codes	35
99215	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	Medication Support Codes	47
99242	Office Consultation for a New or Established Patient. Usually, the Presenting Problem(s) are of Low Severity, 21- 34 Minutes	Therapy Codes	25
99243	Office Consultation for a New or Established Patient. Usually, the Presenting Problem(s) are of Moderate Severity, 35-49 Minutes	Therapy Codes	35
99244	Office Consultation for a New or Established Patient. Usually, the Presenting Problem(s) are of Moderate to High Severity, 50-70 Minutes	Therapy Codes	47
99245	Office Consultation for a New or Established Patient. Usually, the Presenting Problem(s) are of Moderate to High Severity, 71-90 Minutes	Therapy Codes	62
99252	Inpatient Consultation for a New or Established Patient. Usually, the Presenting Problems(s) are of Low Severity, 30- 49 Minutes	Therapy Codes	40
99253	Inpatient Consultation for a New or Established Patient. Usually, the Presenting Problems(s) are of Moderate Severity, 50-69 Minutes	Therapy Codes	52
99254	Inpatient Consultation for a New or Established Patient. Usually, the Presenting Problems(s) are of Moderate to High Severity, 70-90 Minutes	Therapy Codes	70
99255	Office Consultation for a New or Established Patient. Usually, the Presenting Problem(s) are of Moderate to High Severity, 91-130 Minutes	Therapy Codes	87

EXHIBIT B-3 MHS
ENTITY RATES AND CODES BY SERVICE TYPE (CONTINUED)

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
99341	Home Visit of a New Patient, 15-25 Minutes	Medication Support Codes	22
99342	Home Visit of a New Patient, 26-35 Minutes	Medication Support Codes	45
99344	Home Visit of a New Patient, 51-65 Minutes	Medication Support Codes	67
99345	Home Visit of a New Patient, 66-80 Minutes	Medication Support Codes	82
99347	Home Visit of an Established Patient, 10-20 Minutes	Medication Support Codes	25
99348	Home Visit of an Established Patient, 21-35 Minutes	Medication Support Codes	35
99349	Home Visit of an Established Patient, 36-50 Minutes	Medication Support Codes	50
99350	Home Visit of an Established Patient, 51-70 Minutes	Medication Support Codes	67
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Plan Development Codes	60
99367	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	Plan Development Codes	60
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	Plan Development Codes	60
99441	Telephone Evaluation and Management Service, 5-10 Minutes	Assessment Codes	8
99442	Telephone Evaluation and Management Service, 11-20 Minutes	Assessment Codes	16
99443	Telephone Evaluation and Management Service, 21-30 Minutes	Assessment Codes	26
99451	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Minutes	Referral Codes	17
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60
G2212	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	Medication Support Codes	15
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15
H0034	Medication Training and Support, per 15 Minutes	Medication Support Codes	15
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15
T1001	Nursing Assessment/Evaluation, 15 Minutes	Assessment Codes	15
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15

EXHIBIT C

**STANDARD
INDEMNIFICATION
AND
INSURANCE PROVISIONS**

EXHIBIT C
INDEMNIFICATION AND INSURANCE REQUIREMENTS
(For Contracts Involving the Care/Supervision of Children, Seniors or Vulnerable Persons)

INDEMNIFICATION

CONTRACTOR agrees to indemnify, defend (with counsel reasonably approved by COUNTY) and hold harmless COUNTY and its officers, officials, employees, agents and volunteers from and against any and all claims, actions, losses, damages, judgments and/or liabilities arising out of this Agreement from any cause whatsoever, including the acts, errors or omissions of any person or entity and for any costs or expenses (including but not limited to attorneys' fees) incurred by COUNTY on account of any claim except where such indemnification is prohibited by law. CONTRACTOR'S indemnification obligation does not apply to COUNTY'S sole negligence or willful misconduct.

NOTIFICATION OF ACCIDENTS AND SURVIVAL OF INDEMNIFICATION PROVISIONS

CONTRACTOR shall notify COUNTY immediately in the event of any accident or injury arising out of or in connection with this Agreement. The indemnification provisions in this Agreement shall survive any expiration or termination of this Agreement.

INSURANCE

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

1. Minimum Scope of Insurance

Coverage shall be at least as broad as:

- A. Commercial General Liability (CGL):** Insurance Services Office (ISO) Form CG 00 01 covering CGL on an "occurrence" basis, including products-completed operations, personal & advertising injury, with limits no less than \$1,000,000 per occurrence and \$2,000,000 in the aggregate.
- B. Automobile Liability:** Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if CONTRACTOR has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than \$1,000,000 per accident for bodily injury and property damage.

- C. Workers' Compensation:** Insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than \$1,000,000 per accident for bodily injury or disease. ***(Not required if CONTRACTOR provides written verification that it has no employees)***
- D. Professional Liability:** (Errors and Omissions) Insurance appropriate to the CONTRACTOR'S profession, with limit no less than \$2,000,000 per occurrence or claim, \$2,000,000 aggregate.
- E. Sexual Misconduct Liability:** Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than \$2,000,000 per claim and \$2,000,000 aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

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

2. Other Insurance Provisions

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

- A. Additional Insured** – COUNTY, its officers, officials, employees, agents and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the CONTRACTOR'S insurance at least as broad as ISO Form CG 20 10 11 85 or both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; **and** CG 20 37 forms if later revisions used).
- B. Primary Coverage** – For any claims related to this contract, the CONTRACTOR'S insurance coverage shall be primary insurance primary coverage at least as broad as ISO CG 20 01 04 13 as respects the COUNTY, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, officials, employees, or volunteers shall be excess of the CONTRACTOR'S insurance and shall not contribute with it.

- C. Notice of Cancellation** – Each insurance policy required above shall provide that coverage shall not be canceled, except with notice to the COUNTY.
- D. Waiver of Subrogation Rights** – CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of said CONTRACTOR may acquire against the COUNTY by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to effect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.
- E. Deductibles and Self-Insured Retention** – Any deductibles or self-insured retentions must be declared to and approved by the COUNTY. The COUNTY may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.
- F. Acceptability of Insurers** – Unless otherwise approved by Risk Management, insurance shall be written by insurers authorized to do business in the State of California and with a minimum A.M. Best's Insurance Guide rating of "A- VII".
- G. Verification of Coverage** – CONTRACTOR shall furnish the COUNTY with proof of insurance, original certificates and amendatory endorsements as required by this Agreement. The proof of insurance, certificates and endorsements are to be received and approved by the COUNTY before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the CONTRACTOR'S obligation to provide them. The CONTRACTOR shall furnish evidence of renewal of coverage throughout the term of the Agreement. The COUNTY reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.
- H. Failure to Procure Coverage** – In the event that any policy of insurance required under this Agreement does not comply with the requirements, is not procured, or is canceled and not replaced, COUNTY has the right but not the obligation or duty to terminate the Agreement. Maintenance of required insurance coverage is a material element of the Agreement and failure to maintain or renew such coverage or to provide evidence of renewal may be treated by COUNTY as a material breach of contract.
- I. Subcontractors** – CONTRACTOR shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and CONTRACTOR

shall ensure that COUNTY is an additional insured on insurance required from subcontractors.

J. Claims Made Policies – If any of the required policies provide coverage on a claims-made basis:

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

K. Special Risks or Circumstances – COUNTY reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

Any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to this Agreement. CONTRACTOR agrees to execute any such amendment within 30 days of receipt.

Any failure, actual or alleged, on the part of COUNTY to monitor or enforce compliance with any of the insurance and indemnification requirements will not be deemed as a waiver of any rights on the part of COUNTY.

EXHIBIT D
HIPAA BUSINESS ASSOCIATE
AGREEMENT (BAA)
(RESERVED)