TULARE COUNTY AGREEMENT NO. _____

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

THIS AGREEMENT ("Agreement") is entered into as of _____ between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and **STAR VIEW BEHAVIORAL HEALTH, INC.,** a wholly owned subsidiary of **STARS BEHAVIORAL HEALTH GROUP HOLDING COMPANY, INC.,** both California Corporations ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

A. COUNTY wishes to retain the services of CONTRACTOR for the purpose of providing psychiatric beds in the Community Treatment Facility (CTF) and Psychiatric Health Facility (PHF). The CTF and PHF also provide specialty mental health treatment modalities including: Day Treatment Intensive, Medication Support, Mental Health Services, Therapeutic Behavioral Services, Case Management Services, and Crisis Intervention Services; and

B. CONTRACTOR has the experience and qualifications to provide the services COUNTY requires pertaining to the COUNTY'S Mental Health Program; and

C. CONTRACTOR is willing to enter into this Agreement with COUNTY upon the terms and conditions set forth herein.

THE PARTIES AGREE AS FOLLOWS:

1. TERM: This Agreement becomes effective as of July 1, 2020, and expires at 11:59 PM on June 30, 2021, unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement.

2. SERVICES: See attached **Exhibits A, A-1, A-2, A-3 and A-4.**

3. PAYMENT FOR SERVICES: See attached **Exhibits B and B-1.**

4. INSURANCE: Before approval of this Agreement by COUNTY, CONTRACTOR must file with the Clerk of the Board of Supervisors evidence of the required insurance as set forth in the attached **Exhibit C**.

5. GENERAL AGREEMENT TERMS AND CONDITIONS: COUNTY'S "General Agreement Terms and Conditions" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

6. ADDITIONAL EXHIBITS: CONTRACTOR shall comply with the terms and conditions of the Exhibits listed below and identified with a checked box, which are by this reference made a part of this Agreement. Complete Exhibits D, E, F, G, G-1, and H can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

☒	**Exhibit D**	Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
☒	**Exhibit E**	Cultural Competence and Diversity
☒	**Exhibit F**	Information Confidentiality and Security Requirements
☒	**Exhibit G**	Contract Provider Disclosures (Must be completed by Contractor and submitted to County prior to approval of agreement.)
☒	**Exhibit G1**	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
☐	**Exhibit H**	Additional terms and conditions for federally-funded contracts

7. NOTICES: (a) Except as may be otherwise required by law, any notice to be given must be written and must be either personally delivered, sent by facsimile transmission or sent by first class mail, postage pre-paid and addressed as follows**:**

COUNTY:

CONTRACT UNIT
TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY
5957 S. Mooney Boulevard
Visalia, CA 93277
Phone No.: 559-624-8000
Fax No.: 559-713-3718

With a Copy to:

COUNTY ADMINISTRATIVE OFFICER
2800 W. Burrel Ave.
Visalia, CA 93291
Phone No.: 559-636-5005
Fax No.: 559- 733-6318

CONTRACTOR:

STAR VIEW BEHAVIORAL HEALTH, INC.
1501 Hughes Way, Ste. 150
Long Beach, CA 90810
Phone No.: (310) 221-6336
Fax No.: (310) 221-6350

(b) Notice personally delivered is effective when delivered. Notice sent by facsimile transmission is deemed to be received upon successful transmission. Notice sent by first class mail will be deemed received on the fifth calendar day after the date of mailing. Either Party may change the above address by giving written notice under this section.

8. AUTHORITY: CONTRACTOR represents and warrants to COUNTY that the individual(s) signing this Agreement on its behalf are duly authorized and have legal capacity to sign this Agreement and bind CONTRACTOR to its terms. CONTRACTOR acknowledges that COUNTY has relied upon this representation and warranty in entering into this Agreement.

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

9. COUNTERPARTS: The Parties may sign this Agreement in counterparts, each of which is an original and all of which taken together form one single document.

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

STAR VIEW BEHAVIORAL HEALTH, INC.

Date: July 31, 2020

By _____
Print Name Kent Dunlap
Title President & CEO

Date: August 3, 2020

By _____
Print Name Olivia Aranda
Title VP & CFO

[Pursuant to Corporations Code section 313, County policy requires that contracts with a Corporation be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a Limited Liability Company be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

COUNTY OF TULARE

Date: _____

By _____
Chairman, Board of Supervisors

ATTEST: JASON T. BRITT
County Administrative Officer/Clerk of the Board
of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form
County Counsel

By Ameet K. Nagra 8/3/20
Deputy
Matter # 2020801

STAR VIEW ADOLESCENT CENTER

STATEMENT OF WORK

Fiscal Year 2020-2021

1. Program Description:

At times there are children / youth who as a result of their mental health issues need to receive intensive psychiatric evaluation and treatment services. *Star View Adolescent Center* provides acute inpatient psychiatric care, residential care enhanced by intensive mental health services, and schooling to California youth with severe emotional and behavioral disorders and to their families. *Star View* is a secure and structured multidisciplinary treatment program for youth who cannot live safely in family homes or lower level group care because of the nature and severity of their emotional and behavioral problems.

Star View's locked Psychiatric Health Facility (PHF) and Community Treatment Facility (CTF) offer alternatives to repeated psychiatric hospitalization and placement failures. *Star View* stabilizes, provides treatment, and then transitions youth to less restrictive placements, including with family, foster families, or lower level group homes as part of each youth's long term permanency plan.

Star View's CTF services are provided by Star View Children and Family Services, Inc. Star View's PHF and outpatient mental health services are provided by Star View Behavioral Health, Inc.

The PHF is utilized for psychiatric evaluation and acute services for children / youth who are placed in the CTF, prior to transition to the CTF, and for CTF residents who experience an acute crisis. Children / youth fall within the following criteria:

- As a result of serious emotional disturbance there are children/adolescents who as either dependents (Child & Family Services) or wards (Juvenile Probation) of the court or covered under AB 114 (Educationally Related Mental Health Services) and meet the criteria for placement in a CTF. When these children / youth experience psychiatric crises, they meet medical necessity criteria for treatment on a PHF. PHF services are a covered Medi-Cal benefit for this population of children and adolescents.
- AB 114 does not cover PHF services. The outpatient mental health services provided for CTF clients can be covered either by AB 114 or MediCal. Either the school district or the county will need to pay for PHF and outpatient mental health services for any referred children / youth.

Star View Adolescent Center is a comprehensive residential program developed in partnership with the Los Angeles County Departments of Mental Health and Child and Family Services to:

- Provide the highest level of integrated treatment services for youth who otherwise would need to be placed in psychiatric hospitals, or who would experience repeated placement failure and shelter stays.

- Provide strength-based, family-centered, culturally relevant and individualized services to enable the child to transition to a more normalized, less restrictive living situation.
- Provide specific, need-based remedial experiences that will allow the child to reach normal developmental milestones.
- Provide intensive day treatment services 7 days/week for youth residing in the Star View Community Treatment Facility (CTF) program as per Star View Day Treatment policies and procedures developed with Los Angeles County Mental Health, the host county.
- Provide TBS, as needed, an on-site, individualized, one-to-one behavioral assistance program. It will provide short term immediately available interventions to clients. It will provide youth with skills to effectively manage the behavior(s) or symptoms that are a barrier to achieving and/or maintaining a residence in the least restrictive environment, as per Star View TBS Policies and Procedures developed with Los Angeles County Mental Health, the host county.

A. Psychiatric Health Facility

The 16 bed locked Psychiatric Health Facility provides 24 hour intensive services to the seriously, emotionally, disturbed adolescent. This program provides intensive evaluation and treatment services, including the preparation of comprehensive multidisciplinary assessments by a psychiatrist, psychologist, social worker, rehabilitation therapist, and licensed nurse, the development of a coordinated treatment plan, and the provision of quality acute rehabilitative treatment services by a well qualified staff in a therapeutic milieu. The program has proven to be a successful and less costly alternative to traditional acute in-patient psychiatric hospitalization or state hospital care, and allows for ease of transition to the less restrictive on-site Community Treatment Facility and then to placement in small group homes, family re-unification or independent living.

Most adolescents are admitted involuntarily, under W & I Code Section 5150. All adolescents referred to the program will have a DSM 5 primary diagnosis of mental disorder, and a variety of characteristics, including the following:

Physically assaultive, suicidal ideation's and gestures, self-destructive/ abusive behavior, elopement, sexually acting out, fire setting, socially inappropriate conduct, explosiveness, borderline personality disorders, marginally functional, anti-social behavior, verbally abusive, multiple previous hospitalization, failed placement, alienated or conflicting family relationships periodic need for seclusion, restraint or psychotropic medications, history of paranoia, delusions or hallucinations and depressed or withdrawn behavior.

In some instances, adolescents with episodic psychiatric disorders may have accompanying medical problems which will be monitored and treated by the facility's physicians and nursing staff. Star View Adolescent Center has considerable expertise in treating adolescents with such medical complications as diabetes, asthma, and seizures, believing that it is essential to treat the whole person in order to treat the mental illness.

Relying on this philosophy, adolescents have a physical examination on admission and annually thereafter with medical follow-up by a contract pediatrician, as well as periodic dental, vision and hearing examinations. Other professionals such as podiatrists, audiologists and speech pathologists are available for consultation. Adolescents referred to this program will primarily be admitted as an alternative to other acute inpatient hospital settings.

In some instances, clients who have stabilized on the PHF and no longer meet medical necessity to claim services to MediCal will not be able to transition to the CTF because the CTF does not have a bed available. The client will need to either be discharged to another treatment location or to the community or continue PHF services funded through an Administrative Day.

B. Community Treatment Facility

The Star View CTF program will provide residential treatment services for clients under the age of 18 on a 24-hr/7-day/week basis to youngsters requiring a secured treatment facility due to their severe emotional disorder. CTF residential services will include 24-hour supervision and nursing care, activity program, social services supports, and room and board. Mental health services will be provided as medically necessary and designated per treatment plan and are described in Section C, below.

Child and family involvement during placement: Family visits during their child's placement at Star View are necessary for support of the child and family and for parent participation in education and treatment conferences. It is the responsibility of the placing school district to ensure there is timely access for family visits to Star View and for the child to visit the family. With school district prior authorization, Star View can arrange for transportation, meals and lodging on the placing school district's behalf and invoice for reimbursement of the expenses incurred. Prior to placement, the placing school district contracts for the following:

- Transportation, meals & lodging arrangements, including expenses (per diem or cost reimburse up to an amount).
- Aftercare service post-placement: Client discharge planning can call for aftercare services to be provided to ensure a successful transition to the community. In order to develop a thorough discharge plan with provider roles defined, placing school districts are asked to designate an aftercare provider prior to discharge planning. Placing school districts may ask that Star View provide authorized aftercare services. When Star View is asked to provide authorized aftercare services, the rates for mental health services provided during placement will apply for aftercare.
- Provision of acute medical and psychiatric care: The placing school district needs to determine, arrange and pay for any needed acute care.
- One-to-one Client Observation: If the placing school district desires one-to-one client observation for safety reasons, on the PHF or CTF, the placing school district will pre-authorize and pay for one-to-one client observation at the rate of $25.00 per hour. One-to-one service will be employed after all Medi-Cal

reimbursable services have been used to the maximum extent allowable per State policy.

C. Day Treatment Intensive and Other Outpatient Mental Health Services

This program will provide intensive day treatment to residents of the Community Treatment Facility (CTF).

Additional mental health services may be provided as needed. These services shall be individualized according to client needs and are expected to include:

- Medication Support Services
- Crisis Intervention
- Case Management
- Therapeutic Behavioral Services (TBS) as needed.

Available treatment methods will include intensive day treatment (full day), assessments, medication evaluation and support services, crisis intervention, case management/brokerage services and other mental health services as needed including TBS (Therapeutic Behavioral Services).

All services will be delivered consistent with the Short-Doyle Medi-Cal Rehabilitation Option. Services will be individualized and will consider each person's age, maturational level, culture, family values and structure, educational functioning level and physical health. The peer group is utilized as a major resource for individual support, reality testing and feedback.

Intensive mental health services will be offered to youth placed in the Community Treatment Facility (CTF). Services will include assessment, treatment planning, family and group therapy, medication support, and case coordination with placing agencies (Social Services, Juvenile Probation, and Mental Health Ch 26.5). To address behaviors that place others at risk, individualized therapeutic interventions, specific treatment plan elements and close collaboration with family and County will be provided in order to achieve positive behavioral change while ensuring a safe, supportive environment. The goal will be to provide adequate intensive mental health interventions so that children and adolescents may move to less restrictive/intensive treatment settings.

Activity Therapy Program: This program will include group sessions, activity therapy, high interest activities, and relationship examination and development.

Psychotherapy: Individual/child specialty group and family therapies will be available to every child according to his/her specific needs and prescribed in a manner consistent with his/her treatment plans. Therapeutic interventions/ modalities will be designed to support the achievement of competence, health and positive developmental momentum. In every case, the goal of therapy will be to enhance the psychosocial health and development of the child within the context of the child's families, peer group and community.

Medication: Psychotropic medication will be made available through psychiatric consultation. Monitoring of such medication is routine for those youth for whom it is required to alleviate symptoms resulting from DSM IV diagnosis.

Therapeutic Behavioral Services (TBS) are a one to one therapeutic program, designed to maintain the child/youth's residential placement in the least restrictive environment.

D. Discharge Criteria and Planning:

Clients shall be discharged when they meet the following criteria:

- Upon mutual agreement (client and therapist) that the goals of treatment have been met;
- Upon parent or guardian refusal of services, or refusal to comply with objectives outlined in the Mental Health Services Plan;
- Upon parent or guardian's unilateral decision to terminate treatment;
- Upon a good faith determination by the Star View that the individual youth cannot be effectively served by the program;
- Upon a determination that the individual is a danger to other youth, staff or the individual;
- Upon transfer out of the County, to another mental health program or region. Appropriate follow-up or other service linkage will be made.

E. Case Management:

Comprehensive case management services are included in all Star View programs. These include ongoing collaboration, planning and liaison with other community and county providers, facilities and institutions. Linkages to additional resources are created as needed. Star View has had longstanding relationships with key community resources to ensure clients are receiving appropriate services and support that are beyond the scope of our programs.

F. Referrals:

Referrals:
Star View will accept referrals according to County guidelines established for Day Treatment, other mental health services, and CTF programs. Star View will accept referrals only through designated County referral sources that have been approved by the referring County's Interagency Placement Committee (IPC). Referrals determined by Star View to be inappropriate will be directed to alternative resources appropriate to resolve the presenting issues.

G. Placements and Certifications under Presumptive Transfer:

Presumptive Transfer Placements:
Star View will accept "Presumptive Transfer Placement" referrals for which the responsibility for the provision and funding of mental health services shall transfer to the client's county of residence, Los Angeles County, consistent with Assembly Bill 1299. In the event of a Presumptive Transfer Placement, the County is hereby agreeing to fund Star View's Presumptive Transfer Fee for all days the client is receiving services on either the PHF or CTF and the CTF Supplement Fees for the CTF for days the client is receiving services from the CTF.

Presumptive Transfer Waiver Placements:
Star View will accept referrals for which Presumptive Transfer has been waived, provided that documentation of the waiver is provided to Star View by the County.

Changes in Presumptive Transfer Placements Status:
Star View requests that the County provide a 14 (fourteen) day advance notice if a Presumptive Transfer waiver is to be implemented or discontiued for a youth placed at Star View. This will allow time for enrollment and disenrollment in the County's or the Los Angeles County's systems and allow time to process authorizations for treatment.

Continuing Stay Certifications with Presumptive Transfer:
Documentation of meeting criteria for continuing stay in the CTF every 90 days, in compliance with Title 9, Section 1924, shall be the responsibility of Los Angeles County.

Continuing Stay Certifications with Presumptive Transfer Waiver:
If Presumptive Transfer is waived by County, documentation of meeting criteria for continuing stay in the CTF every 90 days, in compliance with Title 9, Section 1924, shall be the responsibility of County.

H. Confidentiality of Health Information:

All information and records obtained in the course of providing services pursuant to this Agreement shall be confidential and are protected from disclosure by the California Welfare and Institutions code, Section 5328, et seq. and other applicable federal and state laws.

Star View is a Covered Entity within the meaning of the Health Insurance Portability and Accountability Act (HIPAA), and will provide services in conformance therewith.

Star View will disclose to appropriate treatment providers individually identifiable health information concerning clients served pursuant to this Agreement for purposes of securing treatment, and to the extent minimally necessary to accomplish the purpose of coordinating or managing health care and to perform the functions specified in the California Welfare and Institutions Code.

The maintenance, access, disposal and transfer of records shall otherwise be in accordance with professional standards and applicable county, State, and Federal laws and regulations and/or specified regulations of the Substance Abuse and Crime Prevention Act of 2000, detailed in section 9535 of Title 9 CCR.

Any sharing of identifiable health information shall be consistent with the provisions of HIPAA and other applicable federal and state laws relating to the use and disclosure of protected health information.

Records will contain sufficient detail to make it possible for contracted services to be evaluated. Star View shall permit authorized County personnel to make periodic inspections of the records. Star View shall furnish information and patient records such as these personnel may require for monitoring, reviewing and evaluating fiscal and clinical effectiveness, appropriateness, and timeliness of the services being rendered under this contract.

3. Service Delivery Site:

Star View Adolescent Center
4025 West 226th Street
Torrance, CA. 90505
Phone: (310) 373-4556
Fax: (310) 373-2826

Exhibit A-1
STAR VIEW ADOLESCENT CENTER
THERAPEUTIC BEHAVIORAL SERVICES (TBS) FY 2020-2021
Scope of Work

DESCRIPTION

Therapeutic Behavioral Services (TBS) is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health service as defined in Title 9, CCR, Section 1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

TBS SCREENING REQUIREMENTS

All TBS referrals must be reviewed by COUNTY TBS Coordinator prior to services being rendered. Services provided without approval of the TBS Coordinated shall not be reimbursed.

GENERAL REQUIREMENTS

1. CONTRACTOR shall request Mental Health Plan (MHP) payment authorization for TBS in advance of the delivery of services. The requirement for approval in advance of the delivery of TBS applies to direct one-to-one TBS and related service activities, but does not include the initial assessment that determines whether or not TBS criteria are met or to the initial development of TBS client plan. The initial assessment may include observation of the beneficiary in the settings in which TBS is expected to be delivered to note baseline behaviors and make a preliminary assessment of likely interventions. The MHP may reimburse CONTRACT providers for the initial assessment and the initial development of the TBS client plan as a mental health service or as TBS, as determined by the MHP.

2. The MHP shall make decision on CONTRACTOR payment authorization requests for TBS in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

3. Both the initial authorization and subsequent reauthorization decisions shall be made by a Licensed Practitioner of the Healing Arts (LPHA) as required by Title 9, CCR, Section 1830.215. During the term of this Agreement, CONTRACTOR shall have available and shall provide upon request to authorized MHP representatives of the COUNTY, a list of all persons by name, title, professional degree, and experience, who are providing services under this Agreement.

4. CONTRACTOR shall train and maintain appropriate supervision of all persons providing services under this Agreement with particular emphasis on the supervision of para-professionals,

interns, students, and clinical volunteers in accordance with CONTRACTOR'S training of all appropriate staff on applicable State manuals and/or training materials and State and County Policies and Procedures as well as any other matters that COUNTY may reasonably require.

5. The MHP shall issue a decision on a CONTRACTOR's payment authorization request for TBS, three working days from the date the additional information is received or 14 calendar days, whichever is less.

6. MHP retains the authority to set additional standards necessary to manage the delivery of TBS, including but not limited to establishing maximum hours for individual TBS service components (e.g., assessment, client plan development, and collateral services), provided the MHP standards are consistent with applicable state and federal laws and regulations an do not prevent the delivery of medically necessary TBS.

ASSESSMENT

The TBS assessment should be completed within the first 10 days of service by a licensed/waivered staff person. During the first 30 days of service it is suggested that services range between 6-12 hours per week. *If more than suggested hours are required contact with the TBS Coordinator-Managed Care Department, is expected.

The TBS assessment should establish Medical Necessity for TBS by evaluating the child/youth's current behavior (presenting problem/impairment) and documenting the following:

- How the behavior causes a significant impairment in an important area of life functioning,
- A reasonable probability of significant deterioration in an important area of life functioning without TBS services, or
- A reasonable probability that the child/youth would not progress developmentally as individually appropriate without TBS services.

1. The following elements are required documentation components in order to substantiate medical necessity for mental health services. TBS assessments can be separate, or part of a more comprehensive assessment.
   - Presenting Problem: Documentation of a client's chief behavioral impairment, history of the presenting problem(s), including current level of functioning, and current family information including relevant family history.
   - Psychological Factors: Documentation of relevant conditions and psychological factors affecting the client's physical health and mental health, including living situation, educations/vocational situation, daily activities, social support, cultural and linguistic factors, and history of trauma.
   - Mental Health History: Documentation of mental health history and previous mental health treatment: providers, therapeutic modality (e.g. medications, psychosocial treatments) and response. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
   - Medical History: Documentation of the complete, relevant medical history and physical health conditions reported by the child/youth or parent/caregiver. Include the name, address

and current phone number of current source of medical treatment. (Note: All appropriate Releases of Information forms should be completed prior to communication with other treatment providers.)

- Prenatal: Documentation of the prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
- Medication: Documentation about medications the client has received or is receiving to treat medical conditions, including duration of medical treatment. Documentation of allergies or adverse reactions to medications, etc.
- Substance Exposure/Substance Use: Documentation of past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over-the-counter, and illicit drugs.
- Strengths: Documentation of client strengths that may be utilized in strategies for achieving client treatment plan goals
- Risks: Documentation of special status situations that present a risk to client or others, including past or current trauma.
- Mental Status Examination
- Diagnosis: A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-9 code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data.
- Any additional relevant clarifying formulations information.

In addition, a TBS assessment must identify the following:

1. Medi-cal Eligibility
2. Member Eligibility
3. Targeted Behaviors: Identify the child or youth's specific targeted behaviors and/or symptoms that jeopardize continuation of the current residential placement or put the child at risk for psychiatric hospitalization, or the specific targeted behaviors and/or symptoms that are expected to interfere when a child or youth is transitioning to a lower level of residential placement.
4. Clinical Judgment: Provide sufficient clinical information to demonstrate that TBS is necessary to sustain the residential placement, and can be expected to provide a level of intervention necessary to stabilize the child or youth in the existing residential placement or to address behaviors and/or symptoms that jeopardize the child or youth's transition to a lower level of care.
5. Behavior Modification: Identify what observable and measurable changes in behavior and/or symptoms TBS is expected to achieve and how the child's Coordinator or Service Team will know when these services have been successful and can be reduced or terminated.
6. Adaptive Behaviors: Identify skills and positive adaptive behaviors that the child or youth is using now to manage the problem behavior and/or is using in other circumstances that could replace the specified problem behaviors and/or symptoms.

PLAN OF CARE

The initial TBS Plan of Care should be completed in the first 10 days of service. Subsequent Plans of Care are required at 90 days and 150 days. All Plans of Care will be submitted 5 days prior to service block ending date, to Tulare County HHSA, Managed Care Department-TBS Coordinator.

The Plan of Care can be completed by a licensed/waivered staff person or a non licensed staff person with a co-signature of the above. The TBS Plan of Care is separate from the Consumer Wellness Plan and is specific to the delivery of TBS.

1. The TBS Plan of Care provides a detailed description of the treatment including behavior modification strategies for the child/youth. The TBS Plan of Care must include:
    A. Targeted Behaviors: Clearly identified specific behaviors and/or symptoms that jeopardize the residential placement or behaviors that are jeopardizing the transition to a lower of residential placement.
    B. Plan Goals: Specific, observable goals tied to the targeted behaviors or symptoms identified in the TBS Assessment.
    C. Benchmarks: The objectives that are met as the child/youth progresses towards achieving client plan goals.
    D. Interventions: Proposed intervention(s) that will significantly diminish the targeted behaviors.
        1. A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan, which is developed with the family/caregiver, if available, and as appropriate.
        2. A specific description of the changes in the behaviors that the interventions are intended to produce, including an estimated time frame for these changes.
        3. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of refining the intervention plan when the original interventions are not achieving the expected results.
    E. Transition Plan: A transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the client progresses towards achieving plan of care goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the Coordinator or Service Team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers/school personnel with skills and strategies to provide continuity of care when TBS is discontinued, when appropriate in the individual case.
        1. Transitional Age Youth (TAY): As necessary, a plan for transition to adult services when the beneficiary is no longer eligible for TBS (i.e. beneficiary turns 21 years old) and will need continued services. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued upon the beneficiary reaching 21 years of age.
        2. If the beneficiary is between 18 and 21 years of age, it is expected that case management notes, documenting the process of transitioning the beneficiary into Adult Mental Health Services, will be found in the home chart. Document any special circumstances that should be taken into account.

F. Signature: A signature (or electronic equivalent) of, at least, one of the following:
    1. A clinician who developed the Plan of Care or is providing the service(s)
    2. A clinician representing the MHP providing the service
    Note: if the above person is providing the service is not licensed or waivered, a co-signature from a physician, licensed/waivered psychologist, licensed/waivered social worker, or a licensed or registered marriage and family therapist is required.
G. Evidence of the child/youth's degree of participation and agreement with the Plan of Care as evidenced by the child/youth's or legal guardian's signature. If child/youth or legal guardian is unavailable or refuses to sign the client plan, a written explanation must be present in the progress notes why the signature could not be obtained.
H. Evidence that a copy of the Plan of Care was provided to the child/youth or parent/caregiver upon request.

2. Note: TBS Plan of Care updates should document the following:
    A. Any significant changes in the child or youth's environment sine the initial TBS Plan of Care; and
    B. If TBS interventions tried to-date.
3. A clear and specific TBS client plan is a key component in ensuring effective delivery of TBS.

PROGRESS NOTES

A. TBS Progress Notes:
    1. Progress notes should clearly and specifically document the following:
        a) Whether there have been significant changes in the child or youth's environment since the initial development of the TBS Plan of Care.
        b) Whether the TBS provided to the child or youth has not been effective and the child or youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the provider indicating that they have considered alternatives, and only requested additional hours/days for TBS based on the documented expectation that the additional time will be effective.
        c) Whether progress is being made in stabilizing the behaviors and/or symptoms by changing or eliminating maladaptive behaviors and increasing adaptive behaviors.
    2. Documentation is required each day that TBS is delivered.
    3. Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The service may be noted by contact or shift.
    4. Progress Notes must be co-signed by a licensed mental health professional (LMHP) if the TBS coach providing the service is not an LMHP.

PROVIDER GRIEVANCE PROCEDURE

CONRACTOR may appeal a denied, terminated or modified request for services from COUNTY. The written appeal shall be submitted to COUNTY within 30 (thirty) calendar days of the postmark of the notification of the denial, termination or modification. Send appeal to:

Tulare County Health & Human Services Agency
Managed Care Division
5957 S Mooney Blvd
Visalia, CA 93277
ATTN: Grievances'/Appeals

EXHIBIT -ATTACHMENT A2

SERVICE AUTHORIZATION REQUEST

State of California - Health and Human Services Agency | Department of Mental Health

SB 785 Service Authorization Request
MH 5125 (rev. 3/09)

Print Form

Service Authorization Request

For out-of-county organizational providers only.

Client's Name:			DOB:	Age:	CIN OR SSN:
(First)	(Middle)	(Last)			

Requesting Agency:	Contact Person:
Contact Phone Number:	**Contact Fax Number:**
Submitted to (MHP):	**Date Submitted:**
Tulare	

- ☑ Initial Authorization for "Client Assessment" only.
- ○ Initial Authorization (Required documents: "Client Assessment" and "Client Plan")
- ○ Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)
- ○ Annual Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)

(Please note: The MHP may request clarifying information / documentation to process your request for any of the above)

Speciality Mental Health Services Requested	Frequency of Service	Total Units Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Day Treatment Intensive	____ Days/week ○ Half Day ○ Full Day	3 Months			
☐ Day Rehabilitation	____ Days/week ○ Half Day ○ Full Day	6 Months			

Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care:

Service Necessity:

Child/youth requires a day rehabilitation, a structured program of rehabilitation and therapy, to:

1. ☐ Improve personal independence and functioning.
2. ☐ Maintain personal independence and functioning.
3. ☐ Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program program of therapy, which may be:

1. ☐ An alternative to hospitalization.
2. ☐ To avoid placement in a more restrictive environment
3. ☐ To maintain in a community setting.
4. ☐ Other (list): _____

Client Name: ,

Record/Identification Number:

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	____ per ○ Week ○ Month ○ Authorization				
☐ Plan Development	____ per ○ Week ○ Month ○ Authorization				
☐ Individual Therapy	____ per ◉ Week ○ Month ○ Authorization				
☐ Group Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Collateral Services	____ per ○ Week ○ Month ○ Authorization				
☐ Family Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Targeted Case Mgmt	____ per ○ Week ○ Month ○ Authorization				
☐ Medication Support	____ per ○ Week ○ Month ○ Authorization				
☐ Other: _____	____ per ○ Week ○ Month ○ Authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

Client Name: ,

Record/Identification Number:

Diagnosis

List Primary Diagnosis first.

Axis I: P: _____

_____

_____

Axis II: P: _____

_____

Axis III: P: _____

_____

Axis IV: P: _____

_____

Axis V: Current GAF: _____ Past Year GAF (if available) _____

Impairment criteria (Must have one of the following impairments as a result of the DSM diagnosis):

1. ☐ A significant impairment in an important area of life functioning.
2. ☐ A probability of significant deterioration in an important area of life functioning.
3. ☐ A probability of that the client will not progress developmentally as individually appropriate.
4. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Intervention criteria (Must have 5, 6, and 7 or 7 and 8):

5. ☐ The focus of treatment is to address the condition identified in the impairment criteria.
6. ☐ The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate.
7. ☐ The condition would not be responsive to physical health care based treatment.
8. ☐ For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

Authorized by (Printed Name/License): _____ **Date:** _____

Signature: _____ **Authorizer's Phone Number:** _____

ATTACHMENT A-3

TULARE COUNTY MENTAL HEALTH PLAN,

QUALITY MANAGEMENT STANDARDS

The Tulare County Alcohol, Drug and Mental Health Services Department is Tulare County's Medi-Cal Mental Health Plan (MHP) and has established standards for all organizational, individual, and group providers furnishing Specialty Mental Health Services. CONTRACTOR shall adhere to all current MHP policies and procedures (P&P's) in addition to the following standards. In the event of conflicting requirements, current P&P's will supersede the below standards. P&P's may be updated from time to time, and when an update occurs COUNTY shall notify CONTRACTOR and provide the revised P&P's. Copies of all current P&P's are available by contacting the Tulare County Mental Health Managed Care/QI division at (559) 624-8000.

1. Assessment

    A. Assessments shall be completed and/or updated in order to provide support for determinations of Medical Necessity for Specialty Mental Health Services (SMHS). Approvals or re-approvals for SMHS may not be based on any other criteria than Medical Necessity, as described by the California Code of Regulations (CCR) and as further described by Department of Health Care Services and Tulare County policy and procedure.

    B. Initial Assessment: Contractor shall complete an initial assessment to establish medical necessity for all consumers requesting specialty mental health services within fourteen (14) days for adults, and twenty-one (21) calendar days for minors from the consumer's initial visit. The Assessment must be completed in the format designated by the MHP and must be completed and signed by a Licensed Practitioner of the Healing Arts (LPHA).

    C. Assessment Update: As clinically indicated, with best practice being at least annually and/or when clinically significant changes occur in the client's status/condition (e.g. diagnosis change, medical necessity changes), a re-assessment of key indicators of the client's condition will be performed and documented within the chart. Particularly, reassessment will gather information the required to determine if the clinical symptoms, behaviors, and impairments necessary to support medical necessity for Specialty Mental Health Services are present or not.

    D. Content of Assessments shall address the following minimum items and may include additional items described in Tulare County policy and procedure:

        1. In order to provide enough information to support a conferred diagnosis and medical necessity determination, providers must at least address the following areas:

            a) Presenting Problem

            b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health

            c) Mental Health History

            d) Medical History

            e) Medications

            f) Substance Exposure/Substance Use

            g) Client Strengths

            h) Risks, including trauma

i) Mental Status Exam

j) Complete Diagnosis, determined by an LPHA within their respective scope of practice

2. An Assessment shall also include a case formulation section clearly describing support for a given diagnosis and medical necessity determination.

2. Plan of Care

A. Consumer Wellness Plan (CWP): The plan of care shall be completed by the Contractor within thirty (30) days from the first date of current admission.

B. Frequency: The CWP shall be completed by the 30th day in all cases in which services will exceed 30 days. At minimum, the CWP must be updated annually from the date the LPHA signs the prior CWP. CWPs may also be updated whenever clinically indicated but may never be authorized for longer than one (1) year from the date of the LPHA signature on the prior CWP.

C. Content of CWPs shall include the following minimum items and may include additional items described in Tulare County policy and procedure:

1. A description of the impairment(s)/risk/developmental milestones not being met that will be the focus of treatment and the symptoms/behaviors of the included diagnosis causing the impairment(s)/risk/developmental milestones not being met.

a) Consumer plans must be consistent with the primary included diagnosis and resulting impairment(s)/risk/developmental milestones that were identified on the most recent Assessment.

2. Specific, observable or quantifiable goals and objectives.

3. Proposed type(s) of intervention to address the functional impairment(s)/reasonable risk of significant deterioration in current functioning/failure to achieve developmental milestones as identified in the Assessment. Interventions should include description of both the particular service (e.g. ICC, Individual Therapy) and the specific intervention actions pertaining to the service (e.g. motivational interviewing, CBT, referral/linkage to AOD treatment).

4. Proposed duration and frequency of intervention(s).

5. Documentation of the consumer's participation in and agreement with the plan. This includes consumer signature and/or legal representative on the plan and description of the consumer's participation in constructing the plan and agreement with the plan in progress notes.

D. Signature (or electronic equivalent) by a LPHA (the LPHA must be a physician for Medicare or MED-Only consumers) and the consumer and/or consumer's legal representative.

E. Contractor will offer a copy of the consumer plan to the consumer and will document such on the consumer plan.

3. Progress Notes and Billing Records. Services must meet the following criteria, as specified in the MHP's Agreement with the California Department of Health Care Services.

A. All service entries will include the date and time the services were provided.

B. The consumer record will contain timely documentation of care. Services delivered will be recorded in the consumer record as expeditiously as possible, but no later than the timeliness time frame delineated by Tulare County Mental Health policy and procedure.

C. Contractor will document consumer encounters, and relevant aspects of consumer care, including relevant clinical decisions and interventions, in the consumer record.

D. All entries will include the exact number of minutes of service provided and the type of service, the reason for the service as related to how the service addressed the impairment/risk/developmental milestone identified in the Assessment and the CWP, the corresponding consumer plan goal, the clinical intervention provided, the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure or job title..

E. The record must be legible.

F. The consumer record will document referrals to community resources and other agencies, when appropriate.

G. The consumer record will document follow-up care or, as appropriate, a discharge summary.

H. Timeliness/Frequency of Progress Notes

1. Shall be prepared for every service contact including:

a) Mental Health Services (Assessment, Plan Development, Collateral, Individual/ Group/Family Therapy, Individual/Group/Family Rehabilitation);

b) Medication Support Services;

c) Crisis Intervention;

d) Case Management/Targeted Case Management (billable or non-billable).

2. Shall be daily for:

a) Crisis Residential;

b) Crisis Stabilization (1x/23hr);

c) Day Treatment Intensive.

3. Shall be weekly for:

a) Day Treatment Intensive for Clinical Summary;

b) Day Rehabilitation;

c) Adult Residential.

4. On each shift for other services such as Acute Psychiatric Inpatient.

4. Additional Requirements

A. Contractor shall display the Medi-Cal Guide to Mental Health Services Brochures in English and Spanish, or alternate format in their offices. In addition, Contractors shall post grievance and appeal process notices in a visible location in their waiting rooms along with copies of English and Spanish grievance and appeal forms with MHP self-addressed envelopes to be used to send grievances or appeals to the Problem Resolution Coordinator and the Quality Improvement/Managed Care Department.

B. Contractor shall be knowledgeable of and adhere to MHP policies on Beneficiary Rights as outlined in the Guide to Mental Health Services and the Beneficiary Problem Resolution policy and procedure.

a. This includes the issuance of Notice of Adverse Benefit Determination(s) according to frequencies described in the Notice of Adverse Benefit Determination policy and procedure.

C. Contractor shall ensure that direct service staff, attend cultural competency trainings as offered by the County.

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

E. Contractor shall provide timely access to care and service delivery in the following areas as required by the State MHP standards:

1. Where applicable, 24 hours per day, 7 days per week access to "urgent" services (within 48 hours of request or determination of necessity) and "emergency" services (same day);

2. Access to routine mental health services (1st appointment within 10 business days of initial request. When not feasible, Contractor shall give the beneficiary the option to re-contact the Access team and request another provider who may be able to serve the beneficiary within the 10 business day standard);

3. Access to routine psychiatric (first appointment within 15 business days of initial request).

4. The MHP Quality Assurance/Utilization Management team of Tulare County monitors clinical documentation and timeliness of service delivery.

5. The MHP shall monitor the performance of its contractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the contractors' performance to periodic formal review.

6. If the MHP identifies deficiencies or areas of improvement, the MHP and the contractor shall take corrective action.

F. Contractor shall not create, support or otherwise sanction any policies or procedures that discriminate against Medi-Cal beneficiaries. Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or, in the alternative, Contractor shall offer hours of operation that are comparable to those hours offered to Medicaid fee-for-service consumers, if the provider serves only Medicaid beneficiaries.

G. If the State, CMS, or the HHS Inspector General (Office of Inspector General) determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate and audit the subcontractor at any time.

H. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Notwithstanding Paragraph 29, Order of Precedence, of the General Terms and Conditions (GTC) relevant to this agreement, the 10-year records retention period shall apply to all MHP agreements. This requirement supersedes the 5-year retention period in Paragraph 9 in the GTC.

Reference: Service and Documentation Standards of the State of California, Department of Health Care Services.

EXHIBIT A-4

TRANSLATION SERVICES

CONTRACTOR agrees to provide translation services such as, but not limited to, interpreting and sign language to consumers for the provision of services under this Agreement at CONTRACTOR'S sole cost.

Services provided may include:

- AT&T Language Line
- American Sign Language Translation Services, including TTY/TDD California Relay Services
- Orchid Interpreting
- Other interpreting services as deemed necessary to provide the consumer with linguistically and culturally appropriate services

CONTRACTOR will not be allowed to use COUNTY'S language and translation services' providers' accounts. Separate accounts will need to be arranged at CONTRACTOR'S discretion.

If COUNTY at any given time receives charges for CONTRACTOR'S language and translation services, CONTRACTOR will receive an invoice for such charge(s).

Exhibit B
Compensation
Fiscal Year 2020-2021

1. COMPENSATION

a. COUNTY agrees to compensate CONTRACTOR for allowed cost incurred as detailed in **Exhibits A A-1**, **A-2, A-3** and **A-4**, subject to any maximums and annual cost report reconciliation.
b. The maximum contract amount shall not exceed Three Hundred Thousand Dollars ($300,000). Payment shall consist of County, State, and Federal funds. 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. Notwithstanding any other provisions of this Agreement, in no event may CONTRACTOR request a rate that exceeds the contracted rate or request a rate that exceeds CONTRACTOR'S published charge(s) to the general public except if the CONTRACTOR is a Nominal Charge Provider.
c. If the CONTRACTOR is going to exceed the Maximum contract amount due to additional expenses or services, it is the responsibility of the CONTRACTOR to request the amendment and provide all supporting documentation that substantiates the increase. No amendments can be requested after April 1, 2021.
d. CONTRACTOR agrees to comply with Medi-Cal requirements and be approved to provide Medi-Cal services based on Medi-Cal site certification.
e. CONTRACTOR shall be responsible for verifying the Consumer's Medi-Cal eligibility status and will take steps to reactivate or establish eligibility where none exists.
f. CONTRACTOR shall certify that all Units of Service (UOS) listed on the invoice submitted by the CONTRACTOR for any payor sources covered by this Agreement are true and accurate to the best of the CONTRACTOR'S knowledge.
g. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in the **Exhibits A, A-1, A-2, A-3, A-4,** of this Agreement.
h. CONTRACTOR shall permit authorized COUNTY, State and/or Federal agency (ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed hereunder including subcontract support activities and the premises, which it is being performed. The CONTRACTOR shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.
i. In the event the state or federal government denies any or all claims submitted by COUNTY on behalf of the CONTRACTOR, COUNTY will not be responsible for any payment obligation and, accordingly, CONTRACTOR shall not seek payment from COUNTY and shall indemnify and hold harmless COUNTY from any and all liabilities for payment of any or all denied claims, including those claims that were submitted outside the period of time specified in this Agreement.

2. Contract Renewal

a. If applicable, should both parties exercise the right to renew this Contract, the maximum fund amount for this Contract/these Contracts in total per renewal term is identical to the maximum fund amount within the current executed contract unless the Parties agree otherwise.

b. This contract may be renewed if the CONTRACTOR continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The County may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract.

3. ACCOUNTING FOR REVENUES

a. CONTRACTOR shall comply with all County, State, and Federal requirements and procedures, as described in WIC Sections 5709, 5710 and 14710, relating to: (1) the determination and collection of patient/client fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP) (2) the eligibility of patients/clients for Medi-Cal , Medicare, private insurance, or other third party revenue, and (3) the collection, reporting, and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. Grants and 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. 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 the consumer receiving services under this Agreement shall be utilized by CONTRACTOR only for the delivery of mental health service units as specified in this Agreement.

4. INVOICING

a. CONTRACTOR shall submit monthly invoices to Tulare County Mental Health Department, Managed Care, 5957 S. Mooney Blvd, Visalia, Ca 93277, no later than fifteen (15) days after the end of the month in which those expenditures were incurred. The invoice must be supported by a system generated a report that validates services indicated on the invoice.
b. Invoices shall be in the format approved by the Tulare County Health & Human Services Agency. All payments made under this Agreement shall be made within thirty (30) days of submission of all required documentation and in accordance with the COUNTY'S payment cycle.
c. 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 twelve (12) months from the month of service to avoid denial for late billing.

5. COST REPORT:

a. Within sixty (60) days after the close of the fiscal year covered by this Agreement, CONTRACTOR shall provide COUNTY with an accurate and complete Annual Cost Report with a statement of expenses and revenue for the prior fiscal year. The Annual Cost Report shall be prepared by the CONTRACTOR in accordance with all applicable Federal, State, and County requirements and generally accepted accounting principles. CONTRACTOR shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. All revenues received by CONTRACTOR shall be reported in its Annual Cost Report and shall

be used to offset gross cost. CONTRACTOR shall maintain source documentation to support the claimed costs, revenues, and allocations, which shall be available at any time to Designee upon reasonable notice. CONTRACTOR shall be responsible for reimbursement to the County upon final settlement.

b. The Cost Report shall be the final financial and statistical report submitted by CONTRACTOR to COUNTY and shall serve as the basis for a final settlement to the CONTRACTOR. CONTRACTOR shall document that costs are reasonable, allowable, and directly or indirectly related to the services to be provided hereunder.
c. CONTRACTOR must keep records of services rendered to Medi-Cal beneficiaries for ten years or until final cost report settlement, Per W&I Code 14124.1.

6. RECONCILIATION AND SETTLEMENT:

a. COUNTY will reconcile the Annual Cost Report and settlement based on the lower of cost or County Maximum Allowance (CMA). Upon initiation and instruction by the State, COUNTY will perform the Short-Doyle/Medi-Cal Reconciliation with CONTRACTOR.
b. COUNTY will perform settlement upon receipt of State Reconciliation Settlement to the COUNTY. Such reconciliation and settlement will be subject to the terms and conditions of this Agreement and any other applicable State and/or federal statutes, regulations, policies, procedures and/or other requirements pertaining to cost reporting and settlements for Title XIX Short-Doyle/Medi-Cal.

7. REPAYMENT OR REIMBURSEMENT TO STATE OR OTHERS:

a. CONTRACTOR agrees that any repayment or reimbursement that must be made by COUNTY to the State of California or others as a result of an audit or conduct by CONTRACTOR, its agents, officers or employees of the programs or services provided under this Agreement shall be paid by CONTRACTOR, out of its own funds, within thirty (30) days after the parties are notified that repayment or reimbursement is due. For purposes of this provision, it is agreed that offsets made by the state are included within the phrase “repayment or reimbursement.”
b. It is understood that if the State Department of Health Care Services disallows Medi-Cal claims, CONTRACTOR shall reimburse COUNTY for any and all State and Federal Medi-Cal funds for those disallowed claims, regardless of the fiscal year of the disallowance within sixty (60) days of the State disallowing claims.

8. Overpayments and Prohibited Payments:

a. The County may offset the amount of any state disallowance, audit exception, or overpayment for any fiscal year against subsequent claims from the Contractor.
b. Offsets may be done at any time after the county has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the CONTRACTOR.
c. CONTRACTOR shall report to the County within sixty (60) calendar days of payments in excess of amounts specified by contract standards.
d. CONTRACTOR shall retain documentation, policies, and treatment of recoveries of overpayments due to fraud, waste, or abuse. Such documentation should include timeframes, processes, documentation, and reporting.
e. CONTRACTOR shall provide an annual report of such overpayments to the County.

f. The County shall not furnish any payments to the CONTRACTOR if that individual/entity is under investigation for any fraudulent activity. Payments of this manner will be prohibited until such investigations are complete by the County or State.

9. Audit Requirements

a. The CONTRACTOR shall submit any documentation requested by the County or State in accordance to audit requirements and needs. Documentation can be requested any time and must be supplied within a reasonable amount of time.
b. The audit shall be conducted by utilizing generally accepted accounting principles and generally accepted auditing standards.
c. The County will involve the Contractor in developing responses to any draft federal or State audit reports that directly impact the county.

10. Beneficiary Liability

a. Pursuant to Cal. Code Regs., tit. 9, § 1810.365, the CONTRACTOR or an affiliate, vendor, or sub-subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments.
b. Consistent with 42 C.F.R. § 438.106, the CONTRACTOR or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which the State does not pay the Contractor, for costs of covered services for which the State or the Contractor does not pay the Contractor's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

Exhibit B-1

Rates Effective 7/1/20

Star View Adolescent Center
FY 20-21 Rates

SERVICE	Unit of Service	Agency's Fee
INPATIENT SERVICES		
Psychiatric Health Facility	Patient Full Day	**$858.23**
Psychiatric Health Facility Administrative Day	Patient Full Day	**$858.23**
County Supplement*	Patient Full Day	**$95.67**
RESIDENTIAL SERVICES		
Community Treatment Facility STRTP Rate**	Client Month	**TBD**
Community Treatment Facility State Supplement	Client Month	**$2,500.00**
Community Treatment Facility County Supplement	Client Day	**$79.72**
County Supplement*	Client Day	**$95.67**
DAY SERVICES		
Day Treatment - Intensive Services	Client Full Day	**$267.32**
OUTPATIENT SERVICES		
Case Management, Brokerage	Staff Minute	**$2.66**
Mental Health Services	Staff Minute	**$3.44**
Therapeutic Behavioral Services	Staff Minute	**$3.44**
Medication Support	Staff Minute	**$6.36**
Crisis Intervention	Staff Minute	**$5.12**

* The County Supplement only applies to county placements of youth placed at the Community Treatment Facility under presumptive transfer per AB 1299.

** STRTP rate for 20/21 will be the rate set by the California Department of Social Services.

If 1:1 is required - Additional $25/hr will be charged. Prior authorization of the 1:1 services will be received from the County.

EXHIBIT C

PROFESSIONAL SERVICES CONTRACTS
INSURANCE REQUIREMENTS

CONTRACTOR shall provide and maintain insurance for the duration of this Agreement against claims for injuries to persons and damage to property which may arise from, or in connection with, performance under the Agreement by the CONTRACTOR, his agents, representatives, employees and subcontractors, if applicable.

A. Minimum Scope & Limits of Insurance

1. Coverage at least as broad as Commercial General Liability, insurance Services Office Commercial General Liability coverage occurrence form GC 00 01, with limits no less than $1,000,000 per occurrence including products and completed operations, property damage, bodily injury and personal & advertising injury. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2. Insurance Services Office Form Number CA 00 01 covering Automobile Liability of $1,000,000 per occurrence including any auto or, if the CONTRACTOR has no owned autos, hired and non-owned auto coverage. If an annual aggregate applies it must be no less than $2,000,000.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

4. Professional Liability (Errors and Omissions) insurance appropriate to the CONTRACTOR's profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

B. Specific Provisions of the Certificate

1. If the required insurance is written on a claims made form, the retroactive date must be before the date of the contract or the beginning of the contract work and must be maintained and evidence of insurance must be provided for at least three (3) years after completion of the contract work.

2. CONTRACTOR must submit endorsements to the General Liability reflecting the following provisions:

   a. *The COUNTY, its officers, agents, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of work or operations performed by or on behalf of the CONTRACTOR including material, parts, or equipment furnished in connection with such work or operations.*

   b. *For any claims related to this project, the CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, agents, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, agents, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it.*

   c. *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of 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 affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*

d. Each insurance policy required by this agreement shall be endorsed to state that coverage shall not be canceled, except after written notice has been provided to the COUNTY.

3. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the COUNTY for all work performed by the CONTRACTOR, its employees, agents and subcontractors. CONTRACTOR waives all rights against the COUNTY and its officers, agents, officials, employees and volunteers for recovery of damages to the extent these damages are covered by the workers compensation and employers liability.

C. Deductibles and Self-Insured Retentions

Deductibles and Self-insured retentions must be declared and any deductible or self-insured retention that exceeds $100,000 will be reviewed by the COUNTY Risk Manager for approval.

D. Acceptability of Insurance

Insurance must be placed with insurers with a current rating given by A.M. Best and Company of no less than A-:VII and a Standard & Poor's Rating (if rated) of at least BBB and from a company approved by the Department of Insurance to conduct business in California. Any waiver of these standards is subject to approval by the County Risk Manager.

E. Verification of Coverage

Prior to approval of this Agreement by the COUNTY, the CONTRACTOR shall file with the submitting department, certificates of insurance with original endorsements effecting coverage in a form acceptable to the COUNTY. Endorsements must be signed by persons authorized to bind coverage on behalf of the insurer. The COUNTY reserves the right to require certified copies of all required insurance policies at any time.

WAIVERS:

I represent and attest that I am a person authorized to make representations on behalf of the CONTRACTOR, and represent the following:

(mark **X** if applicable)

☐ Automobile Exemption: I certify that _____ does not own nor use vehicles in the performance of the agreement for which this insurance requirement is attached.

☐ Workers' Compensation Exemption: I certify that _____ is not required to carry workers' compensation coverage or has filed an exemption with the State of California as required by law.

I acknowledge and represent that we have met the insurance requirements listed above.

Print Name Kent Dunlap Date: 4/25/2020

Contractor Name Central Star Behavioral Health

Signature _____