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 **TURNING POINT OF CENTRAL CALIFORNIA, INC,** a California Corporation, ("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 maintain Mental Health Programs in Tulare County in conformance with the Welfare and Institutions Code, Division 5, Title 9 and 22 of the California Code of Regulations, The Cost Reporting/Data Collection manual of the State Department of Mental Health and Tulare County Mental Health Annual Plan; 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, A-4, A-5, A-6, A-7.**

3. PAYMENT FOR SERVICES: See attached **Exhibits B, B-1, B-2.**

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
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☒	**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
☐	**Exhibit I**	Compliance Criteria
☐	**Exhibit J**	Assurances
☐	**Exhibit K**	Monitoring and Audit

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:
Turning Point of Central California, Inc.
220 N. Locust Street
Visalia, CA. 93291
Phone No.: 559- 267-1385
Fax No.: 559-636-2105

(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.

TURNING POINT OF CENTRAL CALIFORNIA, INC.

Date: 8/5/2020

By Raymond R Banks

Print Name Raymond Banks

Title Chief Executive Officer

Date: 8/6/2020

By

Print Name Bruce Tyler

Title Chief Financial Officer

[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 Eric M. Scott 8/11/20
Deputy

Matter # 2020815

EXHIBIT A
SCOPE OF SERVICES
FISCAL YEAR 2020-2021

Katie A. Services for Foster Youth living in Tulare County

DESCRIPTION

The proposed services would be provided to Tulare County foster children and youth residing in Tulare County who are referred to in the Katie A. Settlement Agreement (copy located at https://www.dhcs.ca.gov/Documents/KatieASettlementAgreement.pdf) as members of the "Subclass."

Katie A. "Subclass" is identified as children in California who:

a) Have an open child welfare service case; and

b) Are full-scope Medi-Cal (Title XIX) eligible; and

c) Meet the medical necessity criteria for Medi-Cal Outpatient Specialty Mental Health Services (SMHS) as set forth in CCR, Title 9, Section 1830.205 or Section 1830.210; and

d) Are currently in or being considered for wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive Early and Periodic Screening Diagnostic and Treatment (EPSDT) services, including but not limited to therapeutic behavioral services or crisis stabilization/intervention, or

e) Are currently in or being considered for placement in a group home (Rate Classification IO or above), a psychiatric hospital or 24-hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs

CONTRACTOR will:

I. Integrate the delivery of mental health and child welfare services and will provide an array of outpatient specialty mental health and community support services to assist children, youth and their families involved in the Child Welfare Services system.

2. Provide children and families access to effective behavioral health services, improve outcomes, promote wellness and resiliency, and maintain family relationships conducive to healthy emotional development with a service delivery model that aligns with and supports the Katie A. Settlement Agreement.

3. Provide timely, ongoing and uninterrupted mental health services (inclusive of medication support) in an integrated, family-focused, trauma-informed service delivery model that supports the goals of the client plan developed by Tulare County Child Welfare Services.

4. Work collaboratively in an integrated service delivery model within the community to obtain the outcomes, goals and strategies of the Katie A. Core Practice Model;

5. Utilize intensive, individualized and strengths-based services for children and families with services delivered outside of an office setting such as in the home, school or community.

6. Have established clinical competency standards when hiring of direct service staff, and a staff development and training program that is inclusive of trauma-informed practice, the use of the evidence-based treatment approaches of Trauma Focused CBT, Managing and Adapting Practices, and co-occurring competence to serve individuals with mental health and substance use/abuse disorders in the family;

7. Address the demographic make-up and population trends of the Target Population to meet their cultural and linguistic needs in designing and planning for providing appropriate behavioral health services;

8. Hire racially and ethnically diverse staff reflective of the target population to provide or assist with culturally competent, client and family-driven mental health and supportive services;

9. Work closely with schools, physical health providers, other community-based organizations and other support services to identify and achieve a successful outcome for the family through a holistic and comprehensive approach.

10. Have the ability to provide timely services which includes the scheduling of court-ordered assessments within seven (7) business days of receiving referrals, completing mental health assessments within thirty (30) days. Expedited assessments will be scheduled and completed no later than fifteen (15) business days from the date of referral;

11. Provide an array of outpatient specialty mental health services (see exhibit A) that adhere to Medi-Cal medical necessity criteria and are of appropriate intensity, duration and location that will achieve treatment plan goals, improve outcomes, promote wellness and resiliency, and maintain family relationships conducive to healthy emotional development.

12. Provide two new services described in the Katie A. Settlement as Intensive care coordination (ICC) and Intensive home-based services (IHBS). See process as outlined below.

13. Frame the assessment and plan of care for children and families around the following questions:

    - What skills, supports and interventions do the child and family need in order to achieve reunification, and what is the plan for incorporating parents in the treatment process?

    - Are there behavioral red flags that could threaten placement stability? If so, what skills, supports and intervention does the foster/kinship family need to maintain a child and what is the plan for incorporating them in the treatment process?

    - What skills, support and intervention does the child need in order to progress developmentally, behaviorally, socially and emotionally, to function successfully at home, school and in the community and to increase personal resilience?

14. Complete Katie A. Implementation training with Tulare County Managed Care Department.

PROCESS

1. COUNTY Katie A. Liaison will send completed Katie A Screening Packet, which includes the Trauma Focused Screening Tools, Letter of Referral (LOR), LOR Response Form and Releases of Information to the CONTRACTOR and to Managed Care Department via encrypted email.
2. CONTRACTOR will assign an ICC Coordinator and a treating clinician.
3. CONTRACTOR will complete a mental health assessment within two weeks from date the screening tool/referral is received.
4. If the child meets medical necessity, ICC Coordinator will complete a progress note documenting "child meets Katie A subclass criteria."
5. ICC Coordinator (or designee) schedules the initial Child and Family Team (CFT) meeting with all involved parties (minimum of family, child, Tulare County Social Worker, and treating therapist) within 2 weeks of completing the assessment or receiving the completed screening packet.
6. ICC Coordinator holds the initial CFT meeting; discuss and offer Katie A. Service (ICC and IHBS) to the family and child and determine the service intensity of each service.
    a. If the family declines Katie A. Services (ICC and/or IHBS) but the other members of the team (therapist or County Social Worker) disagree, the child will remain as an identified Subclass member and the CONTRACTOR will continue to try and engage the family in services.
    b. All feedback regarding the family's decision will be forwarded to Tulare County Managed Care Department for tracking purposes.
7. While at the meeting the ICC Coordinator will complete the Child and Family Team Plan which is an "all inclusive" plan. (Incorporated Mental Health Treatment as well as the Child Welfare Services Case Plan.)
8. CONTRACTOR treating therapist will complete and update the MH Treatment Plan during the CFT to include ICC and IHBS services as agreed to at the CFT.
9. After the initial CFT the ICC Coordinator will complete the LOR Response Form and will email it along with the updated MH Treatment Plan to the Managed Care Department-Katie A. Liaison.
10. The ICC Coordinator is responsible for scheduling CFT's at minimum every 90 days.
11. The COUNTY Social Worker will be included in all CFT's.
12. CONTRACTOR will not bill for ICC unless COUNTY Social Worker is present at the CFT.
13. ICC is only to be billed for CFT meetings.
14. IHBS can only be billed when it has been added to the MH Treatment Plan and agreed to by all team members.
15. Any change in level of services will need to be agreed to through a CFT.

16. CONTRACTOR will make every effort to work with the family and County Social Worker's schedule in order to have all team members present.

17. If the child completes MH treatment, continues to need treatment but no longer meets Subclass criteria, or disengages from treatment, the ICC Coordinator will contact Tulare County Managed Care Department immediately.

18. COUNTY will continue to track all identified Katie A. Subclass children through the Managed Care Department.

EXHIBIT A-1
SCOPE OF SERVICES
FISCAL YEAR 2020-2021

Therapeutic Behavioral Services (TBS)

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 Coordinator 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 and 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 10 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.

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 diagnosis from the most current Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis from the most current ICD-10 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 transition to a lower of residential placement and that will be the focus of TBS.
    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 since the initial TBS Plan of Care; and
    B. If TBS interventions tried to-date, please list.
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 A-2

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-3

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 A-4
SCOPE OF SERVICES
Fiscal Year 2020-2021

Contractor: TURNING POINT OF CENTRAL CALIFORNIA, INC.
Program: VISALIA YOUTH SERVICES

Reporting Unit Grouping RU 800

I. DESCRIPTION OF SERVICES/INTENT AND GOALS:

A. System-Wide Program Intent and Goals:

1. To maintain the consumer in his/her community and/or at the least restrictive placements;
2. To provide community based services within the context of the consumer's family, culture, language and community;
3. To promote extensive and appropriate coordination and collaboration with other agencies and institutions serving children and families in Tulare County;
4. To direct services towards achieving the consumer's goals, desired results and personal milestones;
5. To act as teams that are the single point of responsibility for coordination of each consumer's service and to follow consumers over time and across programs.
6. Provide quarterly caseload reports of the consumer's served, which will include gender, age, language and ethnicity (GALE), to the Quality Improvement (QI) committee and/or on an as needed basis.

B. Description of Services and Treatment Methods:

Children & Family Service Teams will provide outpatient mental health services under the rehabilitation/recovery model of service delivery. Available treatment methods must include: crisis intervention; individual, group, collateral, and family therapy; assessments; evaluations; medication support services; recovery services; and case management/brokerage services. Services will be provided in a variety of settings; including homes, clinic, and community agencies as necessary and needed by the consumers.

C. Diagnostic Spectrum/Inclusionary Criteria

Children and Families Service Teams will provide services in order to maintain consumers in community settings, achieve agreed upon desired outcomes, and help consumers and families achieve the ability to positively influence their own lives. The diagnostic spectrum includes sixteen (16) diagnoses covered under the Medical Necessity Criteria for Children/Youth Specialty Mental Health Services.

II. PROGRAM PERFORMANCE STANDARDS:

A. The Children and Family Contractor shall accept referrals according to the Tulare County HHSA, Mental Health Branch guidelines established for the Service Teams.

B. Service Teams will conduct an assessment of each consumer referred by an authorized referral source. Those consumers with the most impairment will be given priority.

C. The Contractor will render services in accordance with the Tulare County Mental Health Plan identified target populations.

D. The Contractor will respond to emergency and urgent care situations as defined by California Code of Regulations (CCR) Title 9, Chapter 11.

E. The Tulare County Mental Health Avatar Electronic Health Record will be used to measure the Contractor's adherence to the standards set forth in this contract.

F. Services will be delivered within the Department of Health Care Services, State of California and Tulare County HHSA, Mental Health Branch standards of care.

G. Compliance reviews of Contractor services will result in no more than 5% disallowance per year.

H. Physicians in the employ of the Contractor more than 12 hours per week will attend the Pharmacy Review Committee monthly.

I. Consumers shall be discharged when they meet the following criteria: 1) upon consumer's refusal of services by the legally responsible adult, 2) upon the consumer's or legally responsible adult's unilateral decision to terminate treatment, 3) upon transfer to another program which has been mutually agreed upon, 4) or upon mutual agreement that the goals of treatment have been met, 5) consumer does not meet medical necessity criteria. Appropriate follow-up or other service linkage will be made.

J. A suitable representative of the Contractor shall attend the regularly scheduled meetings, training sessions, seminars, or other meetings as scheduled by the Director of Mental Health or his/her designee.

K. It is expected that the Contractor will ensure that staff responsible for clinical supervision meet community practice standards, code of ethics as set forth by their professional designation and the Medical Board of California, the California Board of Behavioral Sciences, the California Board of Psychology, California Board of Vocational Nursing & Psychiatric Technicians standards and regulations.

III. HOURS OF OPERATION (must meet the needs of the target populations):

A. Hours of operation will be generally Monday – Thursday 8 a.m. – 7 p.m., Friday from 8 am to 5 pm and Saturday from 8 am to 5 pm. for medication support services only. It is understood that the Contractor will have hours of operation that allow for access to services, reduce barriers to treatment and meet the needs of the target population.

IV. STAFFING:

A. Minimum Staffing Requirements:

Staffing shall be provided at least at the minimum licensing requirements as set forth in Title IX, Title XIX, Title XXII and Medi-Cal regulations where applicable or at such higher level as necessary for some programs.

B. Additional Staffing Requirements:

In addition to the above licensing requirements, program staff is expected to possess and be trained in the following background and skills:

- Knowledge and skills in the principles of psychosocial rehabilitation; paraprofessional staff is expected to be trained and receive paraprofessional certification within the first six months of employment;
- Understanding of psychopathology and traditional healing practices within the cultural context of the population served;
- Capability of addressing the diverse consumers' levels of acculturation and biculturality;
- Capability of language and cultural competency;
- Knowledge of multicultural experience;
- Knowledge of the local community resources, available to the consumer population and capability of strong collaboration/coordination with local Contractors of health and human services in the community;
- Knowledge of Family Systems Theory and Practice;
- Knowledge of childhood abuse and trauma;
- Knowledge and skills of culturally proficient assessment and diagnosis of childhood disorders;
- Knowledge of assessment of high risk indicators in the children's and youth populations.

VYS CULTURAL COMPETENCY

Staff Listing

No. of	TYPE OF LICENSE	LANGUAGE CAPABILITY		
FTE	CERTIFICATION OR POSITION TITLE	BILINGUAL NO. FTE	LANGUAGE	FTE
0	LIC. PSYCHOLOGIST	0		0
5	LCSW	1	Spanish	3
1	ASW	0		0
10	LMFT	5	Mien/Hmong/Laos/ASL	13
19	AMFT	13	Spanish	18
0	RN	0		0
4	LVN/LPT	1	Spanish	4
20	MH Rehab Specialist	12	Spanish	16
1	MH Rehab Worker	1	Lahu	1
0	Intake Coordinator	3	Spanish	3

EXHIBIT A-5
SCOPE OF SERVICES
Fiscal Year 2020-2021

Contractor: TURNING POINT OF CENTRAL CALIFORNIA, INC.
Program: VISALIA YOUTH SERVICES - SOUTH

Reporting Unit Grouping RU 820

I. DESCRIPTION OF SERVICES/INTENT AND GOALS:

A. System-Wide Program Intent and Goals:

1. To maintain the consumer in his/her community and/or at the least restrictive placements;
2. To provide community based services within the context of the consumer's family, culture, language and community;
3. To promote extensive and appropriate coordination and collaboration with other agencies and institutions serving children and families in Tulare County;
4. To direct services towards achieving the consumer's goals, desired results and personal milestones;
5. To act as teams that are the single point responsibility for coordination of each consumer's service and to follow consumers over time and across programs.
6. Provide quarterly caseload reports of the consumers served, which will include gender, age, language and ethnicity (GALE), to the Quality Improvement (QI) committee and/or on an as needed basis.

B. Description of Services and Treatment Methods:

Children & Family Service Teams will provide outpatient mental health services under the rehabilitation/recovery model of service delivery. Available treatment methods must include: crisis intervention; individual, group, collateral, and family therapy; assessments; evaluations; medication support services; recovery services; and case management/brokerage services. Services will be provided in a variety of settings; including homes, clinic, and community agencies as necessary and needed by the consumers.

C. Diagnostic Spectrum/Inclusionary Criteria

Children and Families Service Teams will provide services in order to maintain consumers in community settings, achieve agreed upon desired outcomes, and help consumers and families achieve the ability to positively influence their own lives. The diagnostic spectrum includes sixteen (16) diagnoses covered under the Medical Necessity Criteria for Children/Youth Specialty Mental Health Services.

II. PROGRAM PERFORMANCE STANDARDS:

A. The Children and Family Contractor shall accept referrals according to the Tulare County HHSA, Mental Health Branch guidelines established for the Service Teams.

B. Service Teams will conduct an assessment of each consumer referred by an authorized referral source. Those consumers with the most impairment will be given priority.

C. The Contractor will render services in accordance with the Tulare County Mental Health Plan identified target populations.

D. The Contractor will respond to emergency and urgent care situations as defined by California Code of Regulations (CCR) Title 9, Chapter 11.

E. The Tulare County Mental Health Avatar Electronic Health Record will be used to measure the Contractor's adherence to the standards set forth in this contract.

F. Services will be delivered within the Department of Health Care Services, State of California and Tulare County HHSA, Mental Health Branch standards of care.

G. Compliance reviews of Contractor services will result in no more than 5% disallowance per year.

H. Physicians in the employ of the Contractor more than 12 hours per week will attend the Pharmacy Review Committee monthly.

I. Consumers shall be discharged when they meet the following criteria: 1) upon consumer's refusal of services by the legally responsible adult, 2) upon the consumer's or legally responsible adult's unilateral decision to terminate treatment, 3) upon transfer to another program which has been mutually agreed upon, 4) or upon mutual agreement that the goals of treatment have been met, 5) consumer does not meet medical necessity criteria. Appropriate follow-up or other service linkage will be made.

J. A suitable representative of the Contractor shall attend the regularly scheduled meetings, training sessions, seminars, or other meetings as scheduled by the Director of Mental Health or his/her designee.

K. It is expected that the Contractor will ensure that staff responsible for clinical supervision meet community practice standards, code of ethics as set forth by their professional designation and the Medical Board of California, the California Board of Behavioral Sciences, the California Board of Psychology, California Board of Vocational Nursing & Psychiatric Technicians standards and regulations.

III. HOURS OF OPERATION (must meet the needs of the target populations):

A. Hours of operation will be generally Monday – Thursday 8 a.m. – 7 p.m., and Friday from 8 am to 5 pm. It is understood that the Contractor will have hours of operation that allow for access to services, reduce barriers to treatment and meet the needs of the target population.

IV. STAFFING:

A. Minimum Staffing Requirements:

Staffing shall be provided at least at the minimum licensing requirements as set forth in Title IX, Title XIX, Title XXII and Medi-Cal regulations where applicable or at such higher level as necessary for some programs.

B. Additional Staffing Requirements:

In addition to the above licensing requirements, program staff is expected to possess and be trained in the following background and skills:

- Knowledge and skills in the principles of psychosocial rehabilitation; paraprofessional staff is expected to be trained and receive paraprofessional certification within the first six months of employment;
- Understanding of psychopathology and traditional healing practices within the cultural context of the population served;
- Capability of addressing the diverse consumers' levels of acculturation and biculturality;
- Capability of language and cultural competency;
- Knowledge of multicultural experience;
- Knowledge of the local community resources, available to the consumer population and capability of strong collaboration/coordination with local Contractors of health and human services in the community;
- Knowledge of Family Systems Theory and Practice;
- Knowledge of childhood abuse and trauma;
- Knowledge and skills of culturally proficient assessment and diagnosis of childhood disorders;
- Knowledge of assessment of high risk indicators in the children's and youth populations.

VYS CULTURAL COMPETENCY

Staff Listing

No. of	TYPE OF LICENSE	LANGUAGE CAPABILITY		
FTE	CERTIFICATION OR POSITION TITLE	BILINGUAL NO. FTE	LANGUAGE	FTE
0	LIC. PSYCHOLOGIST	0		0
5	LCSW	1	Spanish	3
1	ASW	0		0
10	LMFT	5	Mien/Hmong/Laos/ASL	13
19	AMFT	13	Spanish	18
0	RN	0		0
4	LVN/LPT	1	Spanish	4
20	MH Rehab Specialist	12	Spanish	16
1	MH Rehab Worker	1	Lahu	1
0	Intake Coordinator	3	Spanish	3

EXHIBIT A-6
SCOPE OF SERVICES
Fiscal Year 2020-2021

Contractor: TURNING POINT OF CENTRAL CALIFORNIA, INC.
Program: DINUBA CHILDRENS SERVICES

Reporting Unit Grouping RU 850

I. DESCRIPTION OF SERVICES/INTENT AND GOALS:

A. System-Wide Program Intent and Goals:

1. To maintain the consumer in his/her community and/or at the least restrictive placements;
2. To provide community based services within the context of the consumer's family, culture, speech communication and community;
3. To promote extensive and appropriate coordination and collaboration with other agencies and institutions serving children and families in Tulare County;
4. To direct services towards achieving the consumer's goals, desired outcomes and personal milestones;
5. To act as teams that are the single point of responsibility for coordination of each consumer's service and to follow consumers over time and across programs.
6. Provide quarterly caseload reports of the consumers served, which will include gender, age, language and ethnicity (GALE), to the Quality Improvement (QI) committee and/or on an as needed basis.

B. Description of Services and Treatment Methods:

Children & Family Service Teams will provide outpatient mental health services under the rehabilitation/recovery model of service delivery. Available treatment methods must include: crisis intervention; individual, group, collateral, and family therapy; assessments; evaluations; medication support services; recovery services; and case management/brokerage services. Services will be provided in a variety of settings; including home, clinic, and community agencies as necessary and needed by the consumers.

C. Diagnostic Spectrum/Inclusionary Criteria

Children and Families Service Teams will provide services in order to maintain consumers in community settings, achieve agreed upon desired outcomes, and help consumers and families achieve the ability to positively influence their own lives. The diagnostic spectrum includes sixteen (16) diagnoses covered under the Medical Necessity Criteria for Children/Youth Specialty Mental Health Services.

II. PROGRAM PERFORMANCE STANDARDS:

A. The Children and Family Contractor shall accept referrals according to Tulare County HHSA, Mental Health Branch guidelines established for the Service Teams.

B. Service Teams will conduct an assessment of each consumer referred by an authorized referral source. Those consumers with the most impairment will be given priority.

C. The Contractor will render services in accordance with the Tulare County Mental Health Plan identified target populations.

D. The Contractor will respond to emergency and urgent care situations as defined by California Code of Regulations (CCR) Title 9, Chapter 11.

E. The Tulare County Mental Health Avatar Electronic Health Record will be used to measure the Contractor's adherence to the standards set forth in this contract.

F. Services will be delivered within the Department of Health Care Services, State of California and Tulare County HHSA, Mental Health Branch standards of care.

G. Compliance reviews of Contractor services will result in no more than 5% disallowance per year.

H. Physicians in the employ of the Contractor more than 12 hours per week will attend the Pharmacy Review Committee monthly.

I. Consumers shall be discharged when they meet the following criteria: 1) upon consumer's refusal of services by the legally responsible adult, 2) upon consumer's or legally responsible adult's unilateral decision to terminate treatment, 3) upon transfer to another program which has been mutually agreed upon, 4) or upon mutual agreement that the goals of treatment have been met, 5) consumer does not meet medical necessity criteria. Appropriate follow-up or other service linkage will be made.

J. A suitable representative of the Contractor shall attend the regularly scheduled meetings, training sessions, seminars or other meetings as scheduled by the Director of Mental Health or his/her designee.

K. It is expected that the Contractor will ensure that staff responsible for clinical supervision meet community practice standards, code of ethics as set forth by their professional designation and the Medical Board of California, California Board of Behavioral Sciences, California Board of Psychology, California Board of Vocational Nursing & Psychiatric Technicians standards and regulations.

III. HOURS OF OPERATION (must meet the needs of the target populations):

A. Hours of operation will be generally Monday – Thursday 8 a.m. – 7 p.m., and Friday 8 a.m. – 5 p.m. It is understood that the Contractor will have hours of operation that allow for access to services, reduce barriers to treatment and meet the needs of the target population.

IV. STAFFING:

A. Minimum Staffing Requirements:

Staffing shall be provided at least at the minimum licensing requirements as set forth in Title IX, Title XIX, Title XXII and MediCal regulations where applicable or at such higher level as necessary for some programs.

B. Additional Staffing Requirements:

In addition to the above licensing requirements, program staff is expected to possess and be trained in the following background and skills:

- Knowledge and skills in the principles of psychosocial rehabilitation; paraprofessional staff are expected to be trained and receive paraprofessional certification within the first six months of employment;
- Understanding of psychopathology and traditional healing practices within the cultural context of the population served;
- Capability of addressing the diverse consumers' levels of acculturation and biculturality;
- Capability of language and cultural competency;
- Knowledge of multicultural experience;
- Knowledge of the local community resources, available to the consumer population and capability of strong collaboration/coordination with local Contractors of health and human services in the community;
- Knowledge of Family Systems Theory and Practice;
- Knowledge of childhood abuse and trauma;
- Knowledge and skills of culturally proficient assessment and diagnosis of childhood disorders;
- Knowledge of assessment of high risk indicators in the children's and youth populations.

DCS CULTURAL COMPETENCY

Staff Listing

No. of	TYPE OF LICENSE	LANGUAGE CAPABILITY		
FTE	CERTIFICATION OR POSITION TITLE	BILINGUAL NO. FTE	LANGUAGE	FTE
0	LIC. PSYCHOLOGIST	0		0
2	LCSW	2	Spanish	2
3	ASW	3	Spanish	4
5	LMFT	5	Spanish	5
6	AMFT	5	Spanish	4
0	RN	0		0
2	LVN/LPT	2	Spanish	4
8	MH Rehab Specialist	8	Spanish	8
0	MH Rehab Worker	0		2
0	MH Rehab Aide	0		0

EXHIBIT A-7
SCOPE OF SERVICES
Fiscal Year 2020-2021

Contractor: TURNING POINT OF CENTRAL CALIFORNIA, INC.
Program: SEQUOIA YOUTH SERVICES

Reporting Unit Grouping RU 280

I. DESCRIPTION OF SERVICES/INTENT AND GOALS:

A. System-Wide Program Intent and Goals:

1. To maintain the consumer in his/her community and/or at the least restrictive placements;
2. To provide community based services within the context of the consumer's family, culture, speech communication and community;
3. To promote extensive and appropriate coordination and collaboration with other agencies and institutions serving children and families in Tulare County;
4. To direct services towards achieving the consumer's goals, desired outcomes and personal milestones;
5. To act as teams that are the single point of responsibility for coordination of each consumer's service and to follow consumers over time and across programs.
6. Provide quarterly caseload reports of the consumer's served, which will include gender, age, language and ethnicity (GALE), to the Quality Improvement (QI) committee and/or on an as needed basis.

B. Description of Services and Treatment Methods:

Children & Family Service Teams will provide outpatient mental health services under the rehabilitation/recovery model of service delivery. Available treatment methods must include: crisis intervention; individual, group, collateral, and family therapy; assessments; evaluations; medication support services; recovery services; and case management/brokerage services. Services will be provided in a variety of settings; including home, clinic, and community agencies as necessary and needed by the consumers.

C. Diagnostic Spectrum/Inclusionary Criteria

Children and Families Service Teams will provide services in order to maintain consumers in community settings, achieve agreed upon desired outcomes, and help consumers and families achieve the ability to positively influence their own lives. The diagnostic spectrum includes sixteen (16) diagnoses covered under the Medical Necessity Criteria for Children/Youth Specialty Mental Health Services.

II. PROGRAM PERFORMANCE STANDARDS:

A. The Children and Family Contractor shall accept referrals according to Tulare County HHSA, Mental Health Branch guidelines established for the Service Teams.

B. Service Teams will conduct an assessment of each consumer referred by an authorized referral source. Those consumers with the most impairment will be given priority.

C. The Contractor will render services in accordance with the Tulare County Mental Health Plan identified target populations.

D. The Contractor will respond to emergency and urgent care situations as defined by California Code of Regulations (CCR) Title 9, Chapter 11.

E. The Tulare County Mental Health Avatar Electronic Health Record will be used to measure the Contractor's adherence to the standards set forth in this contract.

F. Services will be delivered within the Department of Health Care Services, State of California and Tulare County HHSA, Mental Health Branch standards of care.

G. Compliance reviews of Contractor services will result in no more than 5% disallowance per year.

H. Physicians in the employ of the Contractor more than 12 hours per week will attend the Pharmacy Review Committee monthly.

I. Consumers shall be discharged when they meet the following criteria: 1) upon consumer's refusal of services by the legally responsible adult, 2) upon consumer's or legally responsible adult's unilateral decision to terminate treatment, 3) upon transfer to another program which has been mutually agreed upon, 4) or upon mutual agreement that the goals of treatment have been met, 5) consumer does not meet medical necessity criteria. Appropriate follow-up or other service linkage will be made.

J. A suitable representative of the Contractor shall attend the regularly scheduled meetings, training sessions, seminars or other meetings as scheduled by the Director of Mental Health or his/her designee.

K. It is expected that the Contractor will ensure that staff responsible for clinical supervision meet community practice standards, code of ethics as set forth by their professional designation and the Medical Board of California, California Board of Behavioral Sciences, California Board of Psychology, California Board of Vocational Nursing & Psychiatric Technicians standards and regulations.

III. HOURS OF OPERATION (must meet the needs of the target populations):

A. Hours of operation will be generally Monday – Thursday 8 a.m. – 7 p.m., Friday 8 a.m. – 5 p.m. It is understood that the Contractor will have hours of operation that allow for access to services, reduce barriers to treatment and meet the needs of the target population.

IV. STAFFING:

A. Minimum Staffing Requirements:

Staffing shall be provided at least at the minimum licensing requirements as set forth in Title IX, Title XIX, Title XXII and MediCal regulations where applicable or at such higher level as necessary for some programs.

B. Additional Staffing Requirements:

In addition to the above licensing requirements, program staff is expected to possess and be trained in the following background and skills:

- Knowledge and skills in the principles of psychosocial rehabilitation; paraprofessional staff are expected to be trained and receive paraprofessional certification within the first six months of employment;
- Understanding of psychopathology and traditional healing practices within the cultural context of the population served;
- Capability of addressing the diverse consumers' levels of acculturation and biculturality;
- Capability of language and cultural competency;
- Knowledge of multicultural experience;
- Knowledge of the local community resources, available to the consumer population and capability of strong collaboration/coordination with local Contractors of health and human services in the community;
- Knowledge of Family Systems Theory and Practice;
- Knowledge of childhood abuse and trauma;
- Knowledge and skills of culturally proficient assessment and diagnosis of childhood disorders;
- Knowledge of assessment of high risk indicators in the children's and youth populations.

SYS CULTURAL COMPETENCY

Staff Listing

No. of	TYPE OF LICENSE	LANGUAGE CAPABILITY		
FTE	CERTIFICATION OR POSITION TITLE	BILINGUAL NO. FTE	LANGUAGE	FTE
0	LIC. PSYCHOLOGIST	0		0
0	LCSW	0		0
2	ASW	2	Spanish	0
6	LMFT	4/1	Spanish/Portuguese	6
6	MFTI	4	Spanish	6
0	RN	0		0
2	LVN/LPT	2	Spanish	2
7	MH Rehab Specialist	7	Spanish	7
0	MH Rehab Worker	0		0
0	MH Rehab Aide	0		0

Exhibit B
Compensation
Fiscal Year 2020/2021

1. COMPENSATION

a. COUNTY agrees to compensate CONTRACTOR for allowed cost incurred as detailed in **Exhibit A**, subject to any maximums and annual cost report reconciliation.
b. The maximum contract amount shall not exceed **Fourteen Million, Three Hundred Thousand Dollars ($14,300,000),** and 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 County Maximum Allowance (CMA) or request a rate that exceeds CONTRACTOR'S published charge(s) to the 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) entered/submitted by CONTRACTOR into AVATAR 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 **Exhibit A – A7**
h. CONTRACTOR shall permit authorized COUNTY, State and/or Federal agencies, 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. ACCOUNTING FOR REVENUES

CONTRACTOR shall comply with all County, State, and Federal requirements and procedures, as described in Welfare and Institutions Code (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.
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.

3. INVOICING

a. CONTRACTOR shall submit monthly invoices to the Mental Health Fiscal Analyst at TulareMHP@tularehhsa.org, 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 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.

4. COST REPORT:

a. Within ninety (90) 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 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 from COUNTY, for both contracted and non-contracted services, 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.
b. The Cost Report shall be the final financial and statistical report submitted by CONTRACTOR to COUNTY, and shall serve as the basis for final settlement to CONTRACTOR. CONTRACTOR shall document that costs are reasonable, allowable, and directly or indirectly related to the services to be provided hereunder.

5. 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.

6. 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.

7. INTERIM RATE REVIEW

Interim rates shall be reviewed on a quarterly basis. Within thirty (30) days after the end of the calendar quarters ending September 30, December 31, and March 31, CONTRACTOR shall submit its cost estimate year-to-date with its Units of Time statistics and Cost per Unit on a Service Function basis. Interim Rates should be adjusted to reflect current Cost per Unit, not to exceed the County Maximum Allowed (CMA) for each quarterly review period, the revised Interim Rates shall be effective for services beginning with the first day of the subsequent calendar quarter.

Exhibit B-1
Interim Reimbursement Rate Schedule
Fiscal Year 2020/2021

County of Tulare County
Mental Health Agreement

Service Function	Mode of Service Code	Service Function Code	Time Basis	County Maximum Rates
OUTPATIENT SERVICES	15			
Case Management (including ICC)		01-09	Staff Minute	$2.08
Mental Health Services - Collateral		10-19	Staff Minute	$2.83
Mental Health Services		30-57, 59	Staff Minute	$2.83
Medication Support		60-69	Staff Minute	$4.80
Crisis Intervention		70-79	Staff Minute	$3.73
Therapeutic Behavioral Services		58	Staff Minute	$2.83

EXHIBIT B-2

Electronic Health Records Software Charges
Fiscal Year 2020 - 2021

Turning Point of Central California, Inc.

CONTRACTOR understands that COUNTY utilizes Netsmart's Avatar for its Electronic Health Records management. CONTRACTOR agrees to reimburse COUNTY for all user license fees for accessing Netsmart's Avatar, as set forth below:

One time per user license fee	$800.00
Yearly hosting fee per user	$426.45
OrderConnect Medication Management Prescriber yearly per user fee	$849.33
Non-Prescriber yearly per user fee	$206.37
EPCS Token per user	$75.00
EPCS Subscription per user	$219.96
Yearly Maintenance fee per user	$212.00
Personal Health Record yearly per user	$59.75
M*Modal Speech Recognition yearly per user	$43.16
CareConnect Direct Secure Messaging yearly per user	$60.00

Yearly maintenance fee per user: Amount determined based on formula listed below:

Formula: [Total Maintenance Amount ÷ Total Number of Users]

Should CONTRACTOR decide not to utilize Netsmart's Avatar for its Electronic Health Records management, CONTRACTOR will be responsible for negotiating to opt out the following contract period. The CONTRACTOR will be responsible for obtaining its own system for Electronic Health Records management. CONTRACTOR shall be responsible for administrative costs incurred by the County as a result of Contractor's disassociation with County's Electronic Health Record System. Administrative costs will be calculated based on the costs to add an additional staff position in the Mental Health Department as a result of the service provided under this Agreement and/or if user licenses are purchased so the contractor will have the minimal functionality to the EHR system for consumer setup and billing purposes. The administrative billing would be performed on a monthly basis by invoice to the contractor.

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 Raymond R. Banks, Chief Executive Officer Date: 6/16/2020

Contractor Name Turning Point of Central California, Inc.

Signature _____