AMENDMENT NO. 2 TO SERVICE AGREEMENT

This Amendment No. 2 to Service Agreement No. 23-278 ("Agreement") is dated June 18, 2024 and is between Central Star Behavioral Health, Inc., a private for-profit Corporation ("Contractor"), and the County of Fresno, a political subdivision of the State of California ("County").

Recitals

A. On June 20, 2023, the County and the Contractor entered into County Service Agreement No. 23-278 ("Agreement") for a qualified agency to provide certain Mental Health Services Act (MHSA) Transitional Age Youth (TAY) Mental Health Services and Supports program to deliver integrated mental health and supportive housing services to the TAY population, ages 16 to 25 years of age, who have a serious mental illness and are at risk of being hospitalized, homeless, and/or incarcerated.

B. On October 24, 2023, the County and the Contractor entered into Amendment No. 1 to the Agreement ("Amendment No. 1"), to update rates for the Transitional Age Youth (TAY) Full Service Partnership (FSP) program.

C. The County and the Contractor now desire to further amend the Agreement to correctly label previously incorrectly labeled exhibits, update the insurance requirements, and to expand service provision for the target population into a Continuum of Care which shall include outpatient and intensive case management service levels for individuals stepping down from the FSP program.

The parties therefore agree as follows:

1. All references in the Agreement to Exhibit A1 shall be deemed references to "Revised Exhibit A1," which is attached and incorporated by this reference.

2. All references in the Agreement to "Exhibit G1" shall be deemed references to "Exhibit G1a and Exhibit G1b." Exhibit G1a and Exhibit G1b are attached and incorporated by this reference.

3. All references in the Agreement to Exhibit H shall be deemed references to "Revised Exhibit H," which is attached and incorporated by this reference.

4. Pages 108 through 110 of the Agreement that was previously labeled as “h” shall be labeled as “Exhibit E.”

5. Pages 111 through 132 of the Agreement that was previously labeled as “h” shall be labeled as “Exhibit F.”

6. Pages 134 through 145 of the Agreement that was previously labeled as “h” shall be labeled as “Exhibit G2.”

7. When both parties have signed this Amendment No. 2, the Agreement, Amendment No. 1, and this Amendment No. 2 together constitute the Agreement.

8. The Contractor represents and warrants to the County that:

a. The Contractor is duly authorized and empowered to sign and perform its obligations under this Amendment.

b. The individual signing this Amendment on behalf of the Contractor is duly authorized to do so and his or her signature on this Amendment legally binds the Contractor to the terms of this Amendment.

9. The parties agree that this Amendment may be executed by electronic signature as provided in this section.

a. An “electronic signature” means any symbol or process intended by an individual signing this Amendment to represent their signature, including but not limited to (1) a digital signature; (2) a faxed version of an original handwritten signature; or (3) an electronically scanned and transmitted (for example by PDF document) version of an original handwritten signature.

b. Each electronic signature affixed or attached to this Amendment (1) is deemed equivalent to a valid original handwritten signature of the person signing this Amendment for all purposes, including but not limited to evidentiary proof in any administrative or judicial proceeding, and (2) has the same force and effect as the valid original handwritten signature of that person.

c. The provisions of this section satisfy the requirements of Civil Code section 1633.5, subdivision (b), in the Uniform Electronic Transaction Act (Civil Code, Division 3, Part 2, Title 2.5, beginning with section 1633.1).

d. Each party using a digital signature represents that it has undertaken and satisfied the requirements of Government Code section 16.5, subdivision (a), paragraphs (1) through (5), and agrees that each other party may rely upon that representation.

e. This Amendment is not conditioned upon the parties conducting the transactions under it by electronic means and either party may sign this Amendment with an original handwritten signature.

10. This Amendment may be signed in counterparts, each of which is an original, and all of which together constitute this Amendment.

11. The Agreement as amended by this Amendment No. 2 is ratified and continued. All provisions of the Agreement and not amended by this Amendment No. 2 remain in full force and effect.

[*SIGNATURE PAGE FOLLOWS*]

The parties are signing this Amendment No. 2 on the date stated in the introductory clause.

Central Star Behavioral Health, Inc.

Kent Dunlap

Kent Dunlap
President/CEO

1501 Hughes Way, Suite 150
Long Beach, CA 90810

County of Fresno

Nathan Magsig, Chairman of the Board of Supervisors of the County of Fresno

Attest:
BERNICE E. SEIDEL
Clerk of the Board of Supervisors
County of Fresno, State of California

By: _____
Deputy

For accounting use only:

Org No.: 56304471
Account No.: 7295
Fund No.: 0001
Subclass No.: 10000

Transition Age Youth (TAY) Continuum of Care

SCOPE OF WORK

ORGANIZATION/CONTRACTOR:	Central Star Behavioral Health, Inc.
CORPORATE ADDRESS:	1501 Hughes Way, Suite 150, Long Beach, California 90810
SITE ADDRESS:	3433 W. Shaw Ave Suite 102, Fresno, CA 93711
PROGRAM DIRECTOR:	Nona Akopyan
CONTRACT PERIOD:	July 1, 2023 – June 30, 2024 (term extension) July 1, 2024 – June 30, 2025 (possible 12-month extension based on satisfactory performance)

I. BACKGROUND

The Contractor has successfully operated a Full-Service Partnership program to serve the Transitional Age Youth of Fresno County over the last five years. The Contractor will build upon evidence-based services and activities to offer an expanded continuum of unduplicated services. Integrated services maximize the use of resources to broaden the scope, intensity, and accessibility of services and supports to transitional age youth in rural and metropolitan areas who might otherwise not receive the services they need.

The Contractor's experience with serving culturally and linguistically diverse individuals has supported outreach, access and appropriate service delivery to populations that may not be adequately served by traditional mental health and other support systems. The resulting service delivery system has proven to be effective in assisting targeted populations with achieving and maintaining wellness and recovery.

The program includes three (3) distinct levels of care: 1) Outpatient (OP) services, 2) Intensive Case Management (ICM), and 3) Full-Service Partnership (FSP).

II. TARGET POPULATION

The TAY program is designed to provide services to individuals between the ages of 16-25 with serious emotional disturbance (SED) or serious mental illness (SMI), who meet medical necessity for and can benefit from Specialty Mental Health Services (SMHS). The program will provide a range of services that will be tailored to everyone's needs for service type, intensity, and duration. Persons served will therefore be assigned to one (1) of three (3) levels of care upon completion of the intake/assessment: Outpatient, Intensive Case Management, or Full Service Partnership.

Any individuals who do not require or benefit from SMHS or need medication only shall be linked to their designated Managed Care Plan (MCP) to receive Non-Specialty Mental Health Services (NSMHS). The Contractor will utilize the Transition of Care Tool to facilitate the linkage to the MCP and coordinate care until successful transition has occurred.

III. LOCATION OF SERVICES

Services will be provided at each Contractor's clinic site, in the community, at home and education locations, whichever is most comfortable for the person served. The Contractor must also be capable of offering services through telehealth-phone and telehealth-video should the need arise.

IV. DESCRIPTION OF SERVICES

The intended benefit of creating a program such as the TAY Continuum of Care with multiple levels of care is for maximum flexibility to move participants seamlessly between levels, as clinically indicated. The Contractor shall provide a level of service and support that will reflect each person's unique and individual needs.

A. Behavioral Health

1. Contractors shall provide these services to all participants in the program. Services will include but are not limited to the following:
    i. Provide support to the individual's family and other members of their social network to help them manage the symptoms and illness of the youth/adult and reduce the level of family and social stress associated with the illness.
    ii. Make appropriate referrals and linkages to services that are beyond that of the Contractors' services under this Agreement or as appropriate when discharging/transitioning a youth/adult from the program.
    iii. Coordinate services with any other community mental health and non-mental health providers as well as other medical professionals.
    iv. Assist persons served with accessing all entitlements or benefits for which they are eligible (i.e., Medi-Cal, SSI, Section 8 vouchers, etc.).
    v. Develop family support and involvement whenever possible.
    vi. Refer person served to supported education and employment opportunities, as appropriate.
    vii. Provide or link to transportation services when it is critical to initially access a support service or gain entitlements or benefits.
    viii. Provide or refer to peer support activities, as appropriate.
    ix. Ensure that clinically appropriate Evidence-Based Practices are utilized in service delivery at all levels of care.
2. Contractor shall deliver a comprehensive specialty mental health program. Behavioral health services include but are not limited to:
    i. Assessment

ii. Treatment or Care planning/Goal setting

iii. Pediatric Symptom Checklist (PSC) 35 and the clinically appropriate version of the Child and Adolescent Needs and Strengths (CANS) assessment

iv. Individual therapy

v. Group therapy

vi. Family therapy

vii. Case management

viii. Consultation

ix. Linkage to additional services and supports.

x. Hospitalization/Post Hospitalization Support

3. Contractors will ensure that all services:

   i. Be values-driven, strengths based, individual-driven, and co-occurring capable.

   ii. Be culturally and linguistically competent.

   iii. Be age, culture, gender, and language appropriate.

   iv. Include accommodations for individuals with physical disability(ies)

4. Methods for service coordination and communication between program and other service providers shall be developed and implemented consistent with Fresno County Mental Health Plan (MHP) confidentiality rules.

5. Contractor shall maintain up-to-date caseload records of all individuals enrolled in services, and provide individual, programmatic, and other demographic information to DBH as requested.

6. Contractor shall ensure billable specialty mental health services meet any/all County, State, Federal regulations including any utilization review and quality assurance standards and provide all pertinent and appropriate information in a timely manner to DBH to bill Medi-Cal services rendered.

7. Staffing should be appropriate for services needed at each level of care, which should include case managers, therapists, peer support specialists, psychiatrists, and nurses.

B. <u>Levels of Treatment</u>

1. Outpatient (OP)

   i. The OP level of care focuses primarily on therapeutic appointments for individual and group treatment as well as case management and medication services, as

needed. Individuals at this level receive a minimum of one (1) contact per week with at least one (1) of those contacts being face-to-face per month.

ii. Caseload

Maximum caseload: 1:40

iii. Length of Stay

Suggested length of stay is twelve (12) to eighteen (18) months, with each Contractor evaluating the needs of each enrolled individual on an ongoing basis to ensure that the level of care is clinically appropriate.

2. Intensive Case Management (ICM)

i. Individuals at this ICM level of care would benefit from regularly scheduled case management, individual rehabilitation and/or individual therapy. Persons at this level receive a minimum of one (1) to two (2) mental health contacts per week with one of those contacts being face-to-face. These mental health contacts can include but are not limited to individual therapy, family therapy, group therapy, case management, peer support services and/or medication management.

ii. Caseload

maximum caseload: 1:30

iii. Length of Stay

Suggested length of stay is twelve (12) to twenty-four (24) months, with each Contractor evaluating the needs of each enrolled individual on an ongoing basis to ensure that the level of care is clinically appropriate.

3. Full Service Partnership (FSP)

i. This FSP level of care employs the concept of "whatever it takes", which focuses on innovative approaches to "no fail" services. Individuals at this level meet the State-defined FSP criteria and require higher intensity services to meet their needs. FSP has an increased focus on engagement, collaboration with the person served and stabilization to achieve mutually agreed upon treatment goals. Services at this level of care shall be accessible 24/7. Individuals at the FSP level shall receive a minimum of three (3) face-to-face contacts per week.

ii. Caseload

Maximum caseload: 1:15

iii. Length of Stay

Suggested length of stay is eighteen (18) to twenty-four (24) months, with Contractor evaluating the needs of each enrolled individual on an ongoing basis to ensure that the level of care is clinically appropriate.

C. Admission, Termination and Discharge

1. Entry Criteria

Person served must fall into at least one (1) of the following groups for FSP Level services:

i. Group One: Have a substantial impairment in at least two (2) of the following categories because of a serious emotional disturbance/serious mental illness: self-care, school functioning, family relationships, and ability to function in the community. The individual must be at risk of, or already removed from, the home; or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one year without treatment.
ii. Group Two: Displays psychotic features, is at risk of suicide, and/or is at risk of violence due to a mental disorder.
iii. Group Three: Meets special education eligibility requirements under Chapter 26.5 of the Government Code.

They are unserved or underserved AND they are in one of the following situations:

iv. Homeless or at risk of being homeless.
v. Aging out of the child and youth mental health system
vi. Aging out of the child welfare systems
vii. Aging out of the juvenile justice system
viii. Involved in the criminal justice system
ix. At risk of involuntary hospitalization or institutionalization, or
x. Have experienced a first episode of serious mental illness

Individuals under age 21 must meet one (1) of the following criteria for the OP and ICM services:

i. Has a condition placing them at high-risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DBH, involvement in the Child Welfare system, juvenile justice involvement, or experiencing homelessness.
ii. Meets both of the following requirements:
    a. Has at least one (1) of the following: a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing developmentally as appropriate, a need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.
    b. The individual's condition as described above is due to one (1) of the following: a diagnosed mental health disorder, a suspected mental health disorder that has not yet been diagnosed or significant trauma placing the youth at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

Individuals 21 years of age or older must meet both of the following criteria for the OP and ICM services:

i. The person served has one or both of the following: a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning.
ii. The individual's condition as described in paragraph (i) is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. b. A suspected mental disorder that has not yet been diagnosed.

2. Intake and Initial Assessment

The OP and ICM services are considered access points; therefore, individuals can be referred directly to enter the TAY program based on meeting medical necessity for specialty mental health services. Persons may be referred to the program for OP or ICM services through various sources including, but not limited to DBH, schools, individuals, or other agencies.

Individuals will be referred to the TAY program for FSP services through DBH's Youth Wellness Center or Urgent Care Wellness Center. Contractor shall contact the individual within twenty-four (24) hours of receipt of the referral. A face-to-face meeting will be scheduled within three (3) business days to begin the intake process.

For all levels of care, Contractor shall adhere to the timeliness standards set forth by the state and County's DBH. An initial mental health assessment will be completed within a clinically appropriate timeframe. If the timeframe exceeds thirty (30) days, justification for this delay should be clearly represented in the clinical documentation.

3. Termination and Discharge

Individuals referred to the TAY program may be denied services if the individual does not meet medical necessity for specialty mental health services, meets medical necessity for a mental health diagnosis that is not covered by the County's MHP, and/or the individual is over the age of 25 at the time of referral. Persons who are determined to be ineligible for TAY services will be linked to other appropriate services and resources.

Discharge is determined on a case-by-case basis depending on the individual's progress toward individualized treatment goals. Reasons for discharge include the person served refuses or terminates services; the individual is transferred to another program mutually agreed upon by the individual, parent/caregiver, and TAY; mutual agreement that the treatment goals have been met; and/or the individual is 25 years old or older.

V. STAFFING

A. Contractor shall provide the following staffing components, at minimum:

1. Staffing shall be appropriate for services needed at each level of care, which would include any combination of the following classifications: licensed or license-eligible therapists, personal service coordinators, and family specialists.

2. Licensed or license-eligible therapists:

   Provide linkages and therapeutic services to enrolled individuals and as identified in the Individual Services and Supports Plan (ISSP).

3. Peer Support (or equivalent): Shall be occupied by a former person served or family member with comparable experience to the youth, adult, and/or family receiving services.

4. Personal Service Coordinators (PSC): At least one (1) of the PSC positions shall be occupied by a former person served or family member with comparable experience to the youth, adult, and/or and family receiving services. These positions shall be recruited based on linguistic and cultural needs of the targeted population (e.g., Latino, Southeast Asian, African American, Native American). A bachelor's degree level is preferred for the requirements of the PSC positions; however, 12 college units (including psychology, counseling, etc.) with mental health experience can act as a substitute for the bachelor's degree requirement.

   a. Ensure the following is provided by the PSC:

      1. Assign a primary PSC to each individual served at the FSP level of care. The primary PSC will work with each person, and family member when appropriate, to develop the person's ISSP. The ISSP is used to identify the individual's goals and describe the array of services and supports necessary to advance these goals based on the individual's needs and preferences and, when appropriate, the needs and preferences of the person's family. ISSPs are reviewed by DBH's MHP Managed Care during chart audits.

      2. The PSC will act as a single point of responsibility and contact for the delivery of personal service coordination for each person, as assigned. Personal service coordination is the assistance provided to the individual, and their family when appropriate, to access medical, educational, social, vocational, rehabilitative, crisis intervention, or other community services, when needed.

      3. Ensure all individuals that receive personal service coordination services also receive mental health treatment services when a determination is made by qualified staff using clinically proven assessment tools that a person served would benefit from mental health treatment. Contractors shall institute mental health treatment models to meet the mental health treatment needs of the individuals engaged in services offered in this Agreement.

VI. HOURS OF OPERATION

The standard hours of operation will be Monday through Friday 8:00 AM until 5:00 PM; additional services will be provided after 5:00 PM and on weekends, as needed, to address youth, adult, and/or family concerns and/or provide services to persons served who are unavailable for services during standard business hours. Contractor will be required to be available to provide services to the individual by someone who is known to the person served during after hours operations.

Additionally, Contractors shall provide operational and clinical services in the field, as needed, and temporarily extend office hours to accommodate and increase timeliness of services.

FSP services will be available to participants and their families twenty-four (24) hours a day, seven (7) days a week.

VII. GOALS/OUTCOMES

CONTRACTOR will be required to submit measurable outcomes on an annual basis, as identified in DBH's Policy and Procedure Guide (PPG) 1.2.7 Performance Outcomes Measures, attached as Exhibit E. Performance outcomes measures must be approved by COUNTY's DBH and satisfy all State and local mandates. COUNTY's DBH will provide technical assistance and support in defining measurable outcomes. All performance indicators will reflect the following four

(4) domains: effectiveness, efficiency, access, and satisfaction. These are defined below:

A. **Full Service Partnership:**

1. **Effectiveness**

a) **Psychiatric Hospitalizations** – To assess the degree of effectiveness for FSP level services, CONTRACTOR will track decreases in the number of days hospitalized post-enrollment and compare to the total number of days spent in the psychiatric setting 12 months prior to program enrollment.

b) **Incarcerations** – To reduce the total number of days spent confined in a jail or prison setting, CONTRACTOR will track decreases and compare to the total number of days spent incarcerated 12 months prior to program enrollment.

c) **Homelessness** – To reduce the total number of days spent homeless, CONTRACTOR will track decreases and compare to the total number of days spent homeless 12 months prior to program enrollment.

d) **Medical Hospitalizations** – To reduce the total number of days spent in a hospital or emergency department setting, CONTRACTOR will track decreases and compare to the total number of days hospitalized 12 months prior to program enrollment.

e) **Housing** – Persons served in independent housing will develop a plan for assisting in paying their own housing costs. Persons served will assume responsibility for housing costs when deemed ready and appropriate.

f) **Supplemental Security Income** – Within six (6) months of enrollment, ninety-nine percent (99%) of persons served without SSI will have made SSI applications.

CONTRACTOR shall provide a written report regarding these goals on a semi-annual basis.

g) **Productivity** – Direct service productivity rate shall be a minimum of sixty-five percent (65%).

2. **Efficiency**

a) **Cost Per Person served** – CONTRACTOR will efficiently use resources and maintain or minimize costs per person served. Costs include all staffing and overhead costs associated with program operations.

3. **Access**

a) **Length of Time from Referral to First Contact** – CONTRACTOR will provide timely service for persons served requesting services. The goal wait time from referral to first contact is within three (3) business days.

b) **Length of Time from Referral to First Intake/Assessment Appointment** – The goal wait time from referral to first intake/assessment appointment is within ten (10) business days.

c) **Length of Time from Referral to First Psychiatry Appointment** – The goal wait time from referral to first psychiatry appointment is within fifteen (15) business days.

4. **Satisfaction**

a) **Consumer Perception Survey** – CONTRACTOR will gauge satisfaction of persons served and collect data for service planning and quality improvement. The surveys are conducted every six (6) months over a week period. Program beneficiaries are encouraged to participate in completing the survey. The goal is for 75% of persons served to be satisfied for each domain.

B. **Intensive Case Management / Outpatient**

1. **Effectiveness**

a) **Psychiatric Hospitalization** – To prevent hospitalizations and re-admissions for persons served, CONTRACTOR will provide effective preventive interventions and provide timely post-hospitalization follow-up services. The goal expectancy is for 10% or less of OP/ICM persons served to experience a psychiatric hospitalization. Post-hospitalization follow-up services will occur within ten (10) days or less.

b) **Inpatient Crisis Stabilization Services** – To prevent crisis stabilization services and re-occurrence of crisis stabilization services, CONTRACTOR will provide effective preventative interventions and timely post-crisis stabilization follow up services. The goal is for ten percent (10%) or less of OP/ICM persons served to experience a crisis stabilization service.

c) **Compliance** – CONTRACTOR will comply with all requirements of the DBH Managed Care Organizational Provider Manual.

d) **Supplemental Security Income** – Within six (6) months of enrollment, ninety-nine percent (99%) of persons served without SSI will have made SSI applications. CONTRACTOR shall provide a written report regarding these goals on a semi-annual basis.

e) **Productivity** – Direct service productivity rate shall be a minimum of sixty-five percent (65%).

2. **Efficiency**

a) **Cost Per Person served** – CONTRACTOR will efficiently use resources and maintain or minimize costs per person served.

3. **Access**

a) **Length of Time from Referral to First Contact** – CONTRACTOR will provide timely service for individuals requesting services. The goal wait time from referral to first contact is within three (3) business days.

b) **Length of Time from Referral to First Intake/Assessment Appointment** – The goal wait time from referral to first intake/assessment appointment is within ten (10) business days.

c) **Length of Time from Referral to First Psychiatry Appointment** – The goal wait time from referral to first psychiatry appointment is within fifteen (15) business days.

4. **Satisfaction**

a) **Consumer Perception Survey** – CONTRACTOR will gauge satisfaction of persons served and collect data for service planning and quality improvement. The surveys are conducted every six (6) months over a week period. Program beneficiaries are encouraged to participate in completing the survey. The goal is for 75% of persons served to be satisfied for each domain.

C. Contractor must address each of the categories referenced above and may additionally propose other performance and outcome measures that are deemed best to evaluate the services provided to persons served and/or to evaluate overall program performance. DBH may adjust the performance and outcome measures periodically throughout the duration of the agreement, as needed, to best measure the program as determined by the County. Contractor will be required to utilize and integrate clinical tools as directed by DBH.

D. Contractor must utilize a computerized tracking system with which performance and outcome measures and other relevant data, such as demographics, will be maintained. The data tracking system may be incorporated into the selected Contractor's electronic health record (EHR) or be a stand-alone database. County's DBH must be afforded read-only access to the data tracking system, if applicable.

E. Contractor will be responsible for meeting with DBH on a monthly basis, or more often as agreed upon between DBH and Contractor, for contract and performance monitoring. Contractor will be

required to submit monthly reports to the County that will include, but not be limited to: dollars billed for Medi-Cal and MHSA (non-Medi-Cal) persons served; actual expenses; the number of persons served served/anticipated to be served; utilization of services by persons served; and staff composition. These reports will be due within thirty (30) days after the last day of the previous month or payments may be delayed.

F. Additional reporting is required for FSPs by DHCS via the DCR system to ensure adequate research and evaluation, regarding the effectiveness of services being provided and the achievement of the outcome measures. Contractor will need to report person served/partner information and outcomes of the FSP program directly into the DCR system. Data will be submitted through an online interface using specific forms (see Exhibit F).

G. The Partnership Assessment Form gathers baseline information about the partner and is completed once the partnership is established. Key Event Tracking provides a snapshot of changes in key quality of life areas and is tracked on a continuous basis throughout the course of the FSP. The Quarterly Assessment collects updated information about changes in quality of life areas and is completed every three (3) months from the date the partnership is established.

H. In addition to the requirements set above, the following items listed below represent program goals to be achieved by Contractor. The program's success will be based on the number of goals it can achieve, resulting from performance outcomes. Contractor will utilize a computerized tracking system with which outcome measures and other relevant person served data, such as demographics, will be maintained.

I. Continuous improvement is a core tenant of the Department and MHSA. Over the past few years, County DBH participated in a statewide FSP evaluation project. The result of the project required that DBH should add another question to the State required DCR data as follows:

   a. "How often do you get the social and emotional support that you need? [Response options: *always, usually, sometimes, rarely, never*]

J. Outcomes Regarding Crisis Interventions and Recidivism:

Each enrollee will have no more than six (6) key events (specifically incarceration, homelessness, and crisis or inpatient hospitalization admission) during the first six (6) months in the TAY program. There will be a reduction of key events for enrollees tracked as:

- No more than three (3) key events (incarceration, homelessness, and crisis or inpatient hospitalization admission) during months six to twelve (6-12) of enrollment in program.
- No more than one (1) key event (incarceration, homelessness, and crisis or inpatient hospitalization admission) during months thirteen to eighteen (13-18) of enrollment in program.

1. FSP will reduce days of homelessness after being enrolled in the program, unless person served declined housing assistance. Contractor shall notify DBH of an individual's decline and

document accordingly. Contractor must have clear documentation of efforts to house the person served in an appropriate setting.

2. FSP will show a ninety percent (90%) reduction in days in inpatient psychiatric hospitalizations after being enrolled in the FSP compared to the year prior to enrollment in the FSP.

3. FSP will show a ninety percent (90%) reduction in days incarcerated after being enrolled in the FSP compared to the year prior to enrollment in FSP.

K. Outcomes Regarding Linkages and Referrals:

1. Within ninety (90) days of being enrolled in the FSP, one hundred percent (100%) of persons served who did not have supplemental security income (SSI) will have made applications completed to receive SSI. Contractor will provide this data as requested.

2. Within six (6) months of being enrolled in the FSP, one hundred percent (100%) of persons served will have linkages to and documentation of a Primary Care Physician.

3. Within thirty (30) days of enrollment, one hundred percent (100%) of persons served will have participated in forming their Individual Service Plan.

4. Within one hundred twenty (120) days of enrollment, one hundred percent (100%) of persons served will be provided and/or linked to job coaching activities.

5. Where appropriate, within ninety (90) days of enrollment, at least seventy-five percent (75%) of applicable persons served will have been offered the opportunity to participate in Supportive Education and Employment Services. Within one hundred twenty (120) days of enrollment, at least ninety-five percent (95%) of applicable persons served will have been offered the opportunity to participate in Supportive Education and Employment Services.

Outcomes will be monitored to see if the person served has meaningful use of their time, stays in school or maintains employment, hospitalizations and incarcerations are reduced as well as homelessness. County's DBH will use State criteria for measuring these outcomes.

Contractor will be monitored regarding services delivered and if they meet the goals of the MHSA.

This program will use an effective method likely to bring about intended outcomes, based on one of, or a combination of, the following standards (as defined by current MHSA regulations):

- Evidence-based practice standard
- Promising practice standard
- Community defined practices

Contractor will collect all data and fulfill all reporting requirements as specified in the applicable MSHA regulations related to the program type, strategies, and standards indicated above or as indicated in MHSA regulations. Contractor will work with County to ensure data, outcomes, and reports are included in all required MHSA reports, plans, and updates.

Current MHSA Regulations can be found at the following website: https://mhsoac.ca.gov/wp-content/uploads/MHSA-Jan2020_0.pdf

Contractor should understand all MHSA regulations to ensure they have the organizational capacity to record, track, and report all required elements.

Contractors shall utilize a computerized tracking system with which performance and outcome measures and other relevant person served data, such as demographics, will be maintained. The data tracking system may be incorporated into the Contractors' electronic health records (EHR) systems or in stand-alone databases (e.g., Access or Excel spreadsheets). DBH must be afforded read-only access to the data tracking system. The following items listed below represent program goals to be tracked and achieved by the Contractors during the contract terms.

VIII. TRANSITION OPTIMIZATION FUNDS

One-time Transition Optimization Funds will be available to specialty mental health providers and Drug Medi-Cal providers within FY 2023-24 to encourage Contractors to identify and implement organization changes during the first year of CalAIM Payment Reform to improve outcomes for persons served and create operational efficiencies. Contractor is expected to utilize the strategies, tools and knowledge learned to their programming and continue to improve services for the population served.

A. Funding Allocation Methodology

1. Each participating contractor is eligible to apply for an allocation of Transition Optimization Funds up to the maximum amounts stated in Article 4 of this Agreement and further described below. Transition Optimization Funds will only be available from July 1, 2023 through June 30, 2024 and payments shall be on a quarterly basis.
2. Payments will be disbursed upon review and approval by DBH of each deliverable described below. Quarterly progress reports shall be submitted to DBH in order to show progress as outlined in the submitted plans and deliverables.
3. Payments will be dependent on Contractor demonstrating progress toward meeting deliverables described in this Revised Exhibit B. Contractors who fail to submit progress reports by stated deadlines, or who do not demonstrate adequate progress made, may be determined ineligible for that quarter's payment at the sole discretion of the County.
4. All invoices will be submitted on a quarterly basis within fifteen (15) days following the end of the quarter. Invoices submitted thereafter may not be eligible for payment.

B. Responsibilities

1. Letter of Intent

Contractor shall submit a letter of intent to DBH by July 31, 2023 identifying the selected Transition Optimization Activity(ies) and commitment to meet the deliverable deadlines as described below. The letter shall include all current Medi-Cal billable specialty mental health and substance use disorder services agreements the Contractor has with the County.

The County shall respond to the Contractor's letter of intent within thirty (30) days. The County's response shall include a breakdown of anticipated payments, as determined by the County, depending on the Transition Optimization Activity(ies) chosen and depending on the number of current Medi-Cal billable specialty mental health and substance use disorder services agreements the Contractor has with the County.

2. Quarterly Reports

Contractor shall submit quarterly progress reports and invoices. Reports shall be submitted on the dates indicated in the Schedule of Deliverables below. Invoices are due fifteen (15) days after the end of each quarter. All activities shall be completed by June 30, 2024. The report shall include updated plans/tools and progress Contractor has made toward the Transition Optimization Activity(ies) described in each Contractors' letter of intent.

3. Schedule of Deliverables: Equity Gap Analysis, Fiscal Monitoring Tool, and Electronic Health Record

    i. Q1 Reports: July-Sept:

        1. Letter of Intent: Due July 31, 2023

        2. Fiscal Monitoring Tool, Equity Gap Analysis, and Electronic Health Record Implementation Plans (if applicable): Due September 30, 2023

        3. Fiscal Monitoring Tool Identified Practices and Strategies (if applicable): Due September 30, 2023

    ii. Q2 Report: Oct-Dec: Due January 15, 2024

    iii. Q3 Report: Jan-Mar: Due April 15, 2024

    iv. Q4 Report: Apr-June: Due July 15, 2024

    v. All deliverables will be reviewed and approved by DBH prior to payment.

4. <u>Eligible Transition Optimization Activities</u>

    i. Fiscal Monitoring Tools: Contractor shall submit to DBH a draft of their fiscal monitoring tool that shall be used monthly on an ongoing basis to evaluate fiscal health of the organization. Tools shall, at a minimum, monitor costs, productivity targets and identify one or more practice pattern(s) the organization is employing to increase direct care time to the Medi-Cal population.

        1. <u>Fiscal Monitoring Tools and Implementation Plan</u>: Contractor shall develop fiscal monitoring tools that will be used monthly to ensure their organizational fiscal health and implementation plan. Fiscal monitoring tools drafts and implementation plan shall be submitted to DBH by September 30, 2023.

            i. <u>Identified Practice</u>: Identify at least one process improvement that shall be modified by September 30, 2023.

ii. Quarterly Progress Reports: Quarterly progress reports shall be submitted including but not limited to a narrative of progress, obstacles, alternative solutions and outcomes.

iii. Funding for this activity shall be available up to $25,000 for the initial agreement with Contractor and up to another $10,000 for each additional agreement. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

ii. Equity Gap Analysis: Contractor shall produce a report identifying the race/ethnicity of population served in FY 2022-23 compared to the County's population as provided by the County. Contractor shall identify key disparities in both persons served and amount of services and frequency of transitions to other levels of care received. Contractor shall identify three (3) strategies they shall employ during FY 2023-24 to reduce the disparities among underserved population.

1. Report on Underserved Population: Contractor shall submit an Equity Gap Report to the Department containing including, but not limited to, the following:

i. Identify if it serves specific population within its program(s) and identify whom the program(s) currently served based on data.

ii. Staffing/workforce information and demographics. Report the staffing/workforce supporting the different programs and populations served by the provider in Fresno County. This data is to evaluate how the staffing reflects the populations it is serving.

iii. Comparison of the County penetration rates to the demographics of persons served by the Contractor and program(s) under agreement with DBH.

iv. Data on retention of persons served by demographics. Total persons served and the average length of stay by demographics of the persons served in programs.

i. Which populations are remaining in the programs by demographics, which ones are having the shortest stays.

ii. How long is the average length of stay by the demographics.

v. Identify what data points the Contractor is missing at this time that challenges its ability to thoroughly assess its equity gap analysis. Examples: data is not collected, data that is missing or under reported, data not captured in its processes, etc.

2. Equity Improvement Implementation Plan: Contractor shall submit an Equity Improvement Implementation Plan related to improving health equity by September 30, 2023. The plan shall include the following items at a minimum:

    i. Contractor shall select three (3) strategies from below:

        i. Plan shall include specific efforts including, but not limited to, the following and timelines to increase access to underserved groups.

            1. Outreach/Engagement with underserved communities

            2. Active attendance/participation in DBH's Diversity Equity and Inclusion (DEI) workgroup

            3. Plan for retention of persons served in programs who are under represented

            4. Improvement of demographic data collection including Sexual Orientation Gender Identity (SOGI)/LGBTQ data.

        ii. Plan shall address workforce capacity to render services to more underserved populations, through:

            1. Development of bilingual personnel

            2. Recruitment plan for more diverse workforce to reflect populations served.

            3. Training for workforce to increase capacity to be culturally responsive

            4. Development workforce pool for the future that can be bilingual and bicultural

    ii. Timeline for each effort shall be included in the plan.

    iii. Contractor shall identify the measurement to be used to demonstrate successful implementation of plan. Measure may be identified by the Contractor to best support their plan and goals.

    iv. Contractor shall develop and submit policies and procedures to formally support equity effort.

3. Quarterly Progress Reports: Use available data including but not limited to, External Quality Review Organization (EQRO) and EHR data to evaluate the strategies deployed. Quarterly progress reports shall be submitted including but not limited to a narrative of the progress, obstacles, alternative

solutions and outcomes. The final quarter shall include a comprehensive final report on the outcomes.

4. Funding for this activity shall be available up to $25,000 for the initial agreement with Contractor and up to another $10,000 for each additional agreement. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

C. Electronic Health Record (EHR): The implementation and expansion of the SmartCare EHR is an essential component of improving oversight with the implementation of payment reform. Furthermore, a standardized EHR will improve continuity of care, create transparency across the system, remove obstacles for individuals accessing services and improve the overall outcomes for persons served. For Contractors who plan to opt in to use SmartCare or have previously opted into DBH's former EHR and intend to transition to SmartCare, user fees and costs shall be waived during FY 2023-2024 and FY 2024-2025.

1. Option One: Current EHR Users

i. Strategic Plan: Contractors utilizing DBH's EHR as their current EHR, and who will continue to utilize SmartCare beginning July 1, 2023, shall provide a plan, including, but not limited to, how they will optimize Medi-Cal billing, illustrate how they will utilize the information in the EHR to improve care for persons served, and a training plan for their organization by September 30, 2023.

i. Quarterly Progress Reports**:** Quarterly progress reports shall be submitted, including, but not limited to, a narrative on the progress, obstacles, alternative solutions and outcomes.

ii. Total compensation for this EHR activity, Option 1, shall not exceed $50,000.00 split among all current agreements between the Contractor and the County for Medi-Cal billable specialty mental health and substance use disorder services. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

2. Option Two: Non-EHR Users

i. Contractor shall submit an implementation plan by September 30, 2023 regarding how they will transition to utilizing the SmartCare EHR by June 30, 2024. The plan shall include, at a minimum, an identified Go Live Date, plan on how the current record system will be maintained and utilized, training plan including number of individuals, and additional supports. The Go Live Date must occur by June 30, 2024 to receive final payment. Contractor shall work closely with DBH to identify needs, assignments, collaboration opportunities to transition.

ii. For Option 2, the Contractor shall not be reimbursed more than $200,000 split among all current agreements between the Contractor and the County for Medi-Cal billable specialty mental health and substance use disorder services. The total

maximum compensation available for this option, shall include costs for maintaining current electronic health record/record system and additional supports and training costs per user. Contractor shall transition both specialty mental health and Drug Medi-Cal programming to the County's EHR and shall be required to use the County's EHR for future eligibility agreements with DBH. County shall provide further details on deliverables and payment schedule in County's response to the Contractor's letter of intent.

IX. REPORTS

A. Contractors shall prepare an evaluation report annually, which will be submitted to County's DBH and made available to partnering and interested local agencies and organizations (e.g., project collaborators, other community agencies, and mental health treatment providers). Annual evaluation reports will include the following information: demographics of the target population served, services provided to each participant, number of hospitalizations, enrollment in school, results of data analysis compared to planned process, output and outcome measures, barriers to program implementation and measures taken to overcome those barriers, accomplishments of program participants, lessons learned, and the final result of any and all satisfaction survey(s).

B. Contractors shall be expected to comply with all contract monitoring and compliance protocols, procedures, data collection methods, and reporting requirements conducted by County.

C. Additional reports and outcome information may be requested by County at a later date, as needed.

D. Additional Reporting Requirements

Contractors will be responsible for meeting with DBH on a monthly basis, or more often as agreed upon between DBH and Contractors, for contract and performance monitoring.

Contractors will be required to submit monthly reports to the County that will include, but not be limited to: the number of persons served served/anticipated to be served; utilization of services by persons served; and staff composition. These reports will be due within thirty (30) days after the last day of the previous month or payments may be delayed.

Additional reporting is required for FSPs by DHCS. DHCS uses the FSP Data Collection and Reporting (DCR) system to ensure adequate research and evaluation, regarding the effectiveness of services being provided and the achievement of the outcome measures. Contractors will need to report individual/partner information and outcomes of the FSP program directly into the DCR system. Data will be submitted through an online interface using specific forms. The Partnership Assessment Form gathers baseline information about the partner and is completed once the partnership is established. Key Event Tracking provides a snapshot of changes in key quality of life areas and is tracked on a continuous basis throughout the course of the FSP. The Quarterly Assessment collects updated information about changes in quality of life areas and is completed every three (3) months from the date the partnership is established.

Continuous improvement is a core tenant of the Department and the Mental Health Services Act (MHSA). As a result of a multi-year statewide FSP evaluation project that the County DBH participated in, another question has been added to the State required DCR data as follows:

"How often do you get the social and emotional support that you need?" Response options will be: "always, usually, sometimes, rarely, or never".

X. COUNTY RESPONSIBILITIES:

COUNTY shall:

A. Assist Contractors' efforts to evaluate the needs of each enrolled individual on an ongoing basis to ensure that the level of care each person served is receiving is clinically appropriate.

B. Provide oversight and collaborate with contractors and other County Departments and community agencies to help achieve State program goals and outcomes. Oversight includes, but is not limited to, contract monitoring and coordination with the State Department of Health Care Services in regard to program administration and outcomes.

C. Assist Contractors in making linkages with the total mental health system of care. This will be accomplished through regularly scheduled meetings as well as formal and informal consultation.

D. Participate in evaluating overall program progress and efficiency and be available to contractors for ongoing consultation.

E. Gather outcome information from target person served groups and Contractors throughout each term of this Agreement. County shall notify contractors when their participation is required. The performance outcome measurement process will not be limited to survey instruments but will also include, as appropriate, person served and staff interviews, chart reviews, and other methods of obtaining required information.

F. Assist Contractors' efforts toward cultural and linguistic competency by providing the following to contractors:

    1. Technical assistance and training regarding cultural competency requirements at no cost to contractors.

    2. Mandatory cultural competency training for contractors' personnel, on an annual basis, at minimum.

    3. Technical assistance for translating information into County's threshold languages (Spanish and Hmong). Translation services and costs associated will be the responsibility of contractors.

Fresno County Department of Behavioral Health
Specialty Mental Health Services Outpatient Rates

FSP and AOT	
Provider Type	**Provider Rate Per Hour**
Psychiatrist/ Contracted Psychiatrist	$1,140.98
Physicians Assistant	$511.73
Nurse Practitioner	$567.38
RN	$463.45
Certified Nurse Specialist	$567.38
LVN	$243.47
Pharmacist	$546.16
Licensed Psychiatric Technician	$208.72
Psychologist/Pre-licensed Psychologist	$458.87
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$296.95
Occupational Therapist	$395.28
Mental Health Rehab Specialist	$223.41
Peer Recovery Specialist	$234.58
Other Qualified Providers - Other Designated MH staff that bill	$223.41

Service	**Unit**	**Maximum Units that Can be Billed**	**Rate per Unit**
Interactive Complexity	15 mins per unit	1 per allowed procedure per provider per beneficiary	$16.50
Sign Language or Oral Interpretive Services	15 mins per unit	Variable	$30.00

Fresno County Department of Behavioral Health
Specialty Mental Health Services Outpatient Rates

Field Based **(at least 50% of services are provided in the field)**	
Provider Type	**Provider Rate Per Hour**
Psychiatrist/ Contracted Psychiatrist	$988.85
Physicians Assistant	$443.50
Nurse Practitioner	$491.73
RN	$401.65
Certified Nurse Specialist	$491.73
LVN	$211.00
Pharmacist	$473.34
Licensed Psychiatric Technician	$180.89
Psychologist/Pre-licensed Psychologist	$397.68
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$257.35
Occupational Therapist	$342.58
Mental Health Rehab Specialist	$193.62
Peer Recovery Specialist	$203.30
Other Qualified Providers - Other Designated MH staff that bill medical	$193.62

Revised Exhibit H

Insurance Requirements

1. Required Policies

Without limiting the County's right to obtain indemnification from the Contractor or any third parties, Contractor, at its sole expense, shall maintain in full force and effect the following insurance policies throughout the term of this Agreement.

(A) **Commercial General Liability.** Commercial general liability insurance with limits of not less than Two Million Dollars ($2,000,000) per occurrence and an annual aggregate of Four Million Dollars ($4,000,000). This policy must be issued on a per occurrence basis. Coverage must include products, completed operations, property damage, bodily injury, personal injury, and advertising injury. The Contractor shall obtain an endorsement to this policy naming the County of Fresno, its officers, agents, employees, and volunteers, individually and collectively, as additional insureds, but only insofar as the operations under this Agreement are concerned. Such coverage for additional insureds will apply as primary insurance and any other insurance, or self-insurance, maintained by the County is excess only and not contributing with insurance provided under the Contractor's policy.

(B) **Automobile Liability.** Automobile liability insurance with limits of not less than One Million Dollars ($1,000,000) per occurrence for bodily injury and for property damages. Coverage must include any auto used in connection with this Agreement.

(C) **All-Risk Property Insurance.** All-Risk Property Insurance with no coinsurance penalty provision in an amount that will cover the total of County purchased and owned property in possession of Contractor(s) and/or used in the execution of this Agreement. Contractor must name the County as an Additional Loss Payee.

(D) **Workers Compensation.** Workers compensation insurance as required by the laws of the State of California with statutory limits.

(E) **Employer's Liability.** Employer's liability insurance with limits of not less than One Million Dollars ($1,000,000) per occurrence for bodily injury and for disease.

(F) **Professional Liability.** Professional liability insurance with limits of not less than One Million Dollars ($1,000,000) per occurrence and an annual aggregate of Three Million Dollars ($3,000,000). If this is a claims-made policy, then (1) the retroactive date must be prior to the date on which services began under this Agreement; (2) the Contractor shall maintain the policy and provide to the County annual evidence of insurance for not less than five years after completion of services under this Agreement; and (3) if the policy is canceled or not renewed, and not replaced with another claims-made policy with a retroactive date prior to the date on which services begin under this Agreement, then the Contractor shall purchase extended reporting coverage on its claims-made policy for a minimum of five years after completion of services under this Agreement.

(G) **Molestation Liability.** Sexual abuse / molestation liability insurance with limits of not less than Two Million Dollars ($2,000,000) per occurrence, with an annual aggregate of Four Million Dollars ($4,000,000). This policy must be issued on a per occurrence basis.

(H) **Cyber Liability.** Cyber liability insurance with limits of not less than Two Million Dollars ($2,000,000) per occurrence. Coverage must include claims involving Cyber Risks. The cyber liability policy must be endorsed to cover the full replacement value of damage to, alteration of, loss of, or destruction of intangible property (including but not limited to information or data) that is in the care, custody, or control of the Contractor.

Definition of Cyber Risks. "Cyber Risks" include but are not limited to (i) Security Breach, which may include Disclosure of Personal Information to an Unauthorized Third Party; (ii) data breach; (iii) breach of any of the Contractor's obligations under [identify the Article, section, or exhibit containing data security obligations] of this Agreement; (iv) system failure; (v) data recovery; (vi) failure to timely disclose data breach or Security Breach; (vii) failure to comply with privacy policy; (viii) payment card liabilities and costs; (ix) infringement of intellectual property, including but not limited to infringement of copyright, trademark, and trade dress; (x) invasion of privacy, including release of private information; (xi) information theft; (xii) damage to or destruction or alteration of electronic information; (xiii) cyber extortion; (xiv) extortion related to the Contractor's obligations under this Agreement regarding electronic information, including Personal Information; (xv) fraudulent instruction; (xvi) funds transfer fraud; (xvii) telephone fraud; (xviii) network security; (xix) data breach response costs, including Security Breach response costs; (xx) regulatory fines and penalties related to the Contractor's obligations under this Agreement regarding electronic information, including Personal Information; and (xxi) credit monitoring expenses.

2. Additional Requirements

(A) **Verification of Coverage.** Within 30 days after the Contractor signs this Agreement, and at any time during the term of this Agreement as requested by the County's Risk Manager or the County Administrative Office, the Contractor shall deliver, or cause its broker or producer to deliver, to the County Risk Manager, at 2220 Tulare Street, 16th Floor, Fresno, California 93721, or HRRiskManagement@fresnocountyca.gov, and by mail or email to the person identified to receive notices under this Agreement, certificates of insurance and endorsements for all of the coverages required under this Agreement.

(i) Each insurance certificate must state that: (1) the insurance coverage has been obtained and is in full force; (2) the County, its officers, agents, employees, and volunteers are not responsible for any premiums on the policy; and (3) the Contractor has waived its right to recover from the County, its officers, agents, employees, and volunteers any amounts paid under any insurance policy required by this Agreement and that waiver does not invalidate the insurance policy.

(ii) The commercial general liability insurance certificate must also state, and include an endorsement, that the County of Fresno, its officers, agents, employees, and volunteers, individually and collectively, are additional insureds insofar as the operations under this Agreement are concerned. The commercial general liability insurance certificate must also state that the coverage shall apply as primary insurance and any other insurance, or self-insurance, maintained by the County

shall be excess only and not contributing with insurance provided under the Contractor's policy.

(iii) The automobile liability insurance certificate must state that the policy covers any auto used in connection with this Agreement.

(iv) The professional liability insurance certificate, if it is a claims-made policy, must also state the retroactive date of the policy, which must be prior to the date on which services began under this Agreement.

(v) The cyber liability insurance certificate must also state that it is endorsed, and include an endorsement, to cover the full replacement value of damage to, alteration of, loss of, or destruction of intangible property (including but not limited to information or data) that is in the care, custody, or control of the Contractor.

(B) **Acceptability of Insurers.** All insurance policies required under this Agreement must be issued by admitted insurers licensed to do business in the State of California and possessing at all times during the term of this Agreement an A.M. Best, Inc. rating of no less than A: VII.

(C) **Notice of Cancellation or Change.** For each insurance policy required under this Agreement, the Contractor shall provide to the County, or ensure that the policy requires the insurer to provide to the County, written notice of any cancellation or change in the policy as required in this paragraph. For cancellation of the policy for nonpayment of premium, the Contractor shall, or shall cause the insurer to, provide written notice to the County not less than 10 days in advance of cancellation. For cancellation of the policy for any other reason, and for any other change to the policy, the Contractor shall, or shall cause the insurer to, provide written notice to the County not less than 30 days in advance of cancellation or change. The County in its sole discretion may determine that the failure of the Contractor or its insurer to timely provide a written notice required by this paragraph is a breach of this Agreement.

(D) **County's Entitlement to Greater Coverage.** If the Contractor has or obtains insurance with broader coverage, higher limits, or both, than what is required under this Agreement, then the County requires and is entitled to the broader coverage, higher limits, or both. To that end, the Contractor shall deliver, or cause its broker or producer to deliver, to the County's Risk Manager certificates of insurance and endorsements for all of the coverages that have such broader coverage, higher limits, or both, as required under this Agreement.

(E) **Waiver of Subrogation.** The Contractor waives any right to recover from the County, its officers, agents, employees, and volunteers any amounts paid under the policy of worker's compensation insurance required by this Agreement. The Contractor is solely responsible to obtain any policy endorsement that may be necessary to accomplish that waiver, but the Contractor's waiver of subrogation under this paragraph is effective whether or not the Contractor obtains such an endorsement.

(F) **County's Remedy for Contractor's Failure to Maintain.** If the Contractor fails to keep in effect at all times any insurance coverage required under this Agreement, the County may, in addition to any other remedies it may have, suspend or terminate this

Agreement upon the occurrence of that failure, or purchase such insurance coverage, and charge the cost of that coverage to the Contractor. The County may offset such charges against any amounts owed by the County to the Contractor under this Agreement.

(G) **Subcontractors.** The Contractor shall require and verify that all subcontractors used by the Contractor to provide services under this Agreement maintain insurance meeting all insurance requirements provided in this Agreement. This paragraph does not authorize the Contractor to provide services under this Agreement using subcontractors.