AMENDMENT NO. 1 TO SERVICE AGREEMENT

This Amendment No. 1 to Service Agreement ("Amendment No. 1") is dated _____ and is between Mental Health Systems, Inc., a California nonprofit corporation ("Contractor"), and the County of Fresno, a political subdivision of the State of California ("County").

Recitals

A. On August 5, 2025, the County and the Contractor entered into Agreement No. 25-380 ("Agreement"), for Adult Full-Service Partnership (FSP) Continuum of Care services.

B. In March 2024, California voters passed Proposition 1, which proposed statewide reform and expansion of California's behavioral health system, effectively replacing the Mental Health Services Act ("MHSA") of 2004 with the Behavioral Health Services Act ("BHSA").

C. Welfare and Institutions Code 5887 released on April 17, 2024 requires that Full-Service Partnerships are required to provide high-intensity Specialty Mental Health Services models to adults eighteen (18) years of age and older, and restructures the levels of care for adults eighteen (18) years of age and older effective July 1, 2026 as follows: Full Service Partnership Intensive Case Management and Outpatient Specialty Mental Health Services.

D. In March 2026, the State released new accountability measures for the Community Assistance, Recovery, and Empowerment (CARE) Act. As part of the new accountability measures, the State measures success by petitions per capita. Fresno County fell below the average of 6.2 petitions per capita by 0.2. To meet the State's new measure of success, the Department is implementing a ramp up of activities that consist of, but are not limited to, assertive outreach and engagement and community education.

E. The County and Contractor now desire to amend the Agreement to revise the Scope of Work, Behavioral Health Requirements, Outcomes, Financial Terms and Conditions, Fee for Service Rates, and the budget, to align with BHSA requirements for Full-Service Partnerships and to meet the new accountability measurement for the CARE Act.

The parties therefore agree as follows:

1. All references to Exhibit A shall be deemed references to “Revised Exhibit A”. Revised Exhibit A is attached and incorporated by this reference.

2. All references to Exhibit B shall be deemed references to “Revised Exhibit B”. Revised Exhibit B is attached and incorporated by this reference.

3. All references to Exhibit C shall be deemed references to “Revised Exhibit C”. Revised Exhibit C is attached and incorporated by this reference.

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

5. 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.

6. 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.

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

8. The Agreement as amended by this Amendment No. 1 is ratified and continued. All provisions of the Agreement not amended by this Amendment No. 1 remain in full force and effect.

[*SIGNATURE PAGE FOLLOWS*]

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The parties are signing this Amendment No. 1 on the date stated in the introductory clause.

Mental Health Systems, Inc.	COUNTY OF FRESNO
James C Callaghan Jr James C Callaghan Jr (May 28, 2026 16:13:25 PDT)	
James C. Callaghan, CEO & President	Garry Bredefeld, Chairman of the Board of Supervisors of the County of Fresno
9456 Farnham Street San Diego, CA 92123	**Attest:** Bernice E. Seidel Clerk of the Board of Supervisors County of Fresno, State of California
	By: _____ Deputy

For accounting use only:

Org No.: 56304535 (FSP ICM)
56304575 (OP)
56302833 (AOT)
56304537 (CARE)
Account No.: 7295
Fund No.: 0001
Subclass No.: 10000

FRESNO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH
SCOPE OF WORK
Effective July 1, 2026

I. PROGRAM NAME

Mental Health Systems, Inc. - Daring to Achieve Recovery Together (DART) West

II. BACKGROUND

The Contractor shall operate an Adult Continuum of Care, including the high-intensity services model of Full-Service Partnership Intensive Case Management (FSP ICM), and Outpatient (OP) levels of care services for adults (eighteen (18) years of age and older). Additionally, Contractor will provide outreach and engagement to persons served referred to the program but not yet admitted for all populations.

The Contractor shall work with adults and older adults who are experiencing a range of symptoms qualifying for Specialty Mental Health Services (SMHS) or co-occurring SMHS and Substance Use Disorder (SUD), including those who have a serious disorder that is severe in degree and persistent in duration. As a result of the disorder the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms. Functional impairment may occur in the person's independent living, social relationships, vocational skills, or physical condition. Continuum of Care services are outpatient and voluntary. Enrolled persons served may withdraw consent at any time.

Contractor will maintain staffing in the FSP ICM level appropriate to serve the annual maximum census as stated in Scope of Work Section IV.B.2 below. Outpatient capacity is at the discretion of the Contractor, however, each site will provide sufficient capacity to serve persons currently enrolled in the Adult Continuum of Care programs with additional capacity to serve new persons while continuing to maintain a more intimate level of service to effectively stabilize persons served through engagement with the program. The total maximum capacity of all levels of care is at the Contractor's discretion. Additionally, there is no required ratio between FSP ICM and OP total persons served.

Services provided by FSP ICM teams will include comprehensive mental health, substance use disorder treatment, linkage to housing options and other community-based supports to persons served with a serious mental illness (SMI)/serious emotional disturbance (SED) and/or co-occurring SUD. Contractor is expected to build the OP caseload when stepping down FSP ICM persons and serving significant support persons.

"Whatever it takes": Using any method necessary to engage a person served, determine their needs for recovery, and creating personalized, collaborative services and supports to meet the wellness and recovery needs of the unique person served.

"Meeting the person served where they are": Being accessible and available to persons served at any time, meeting in a location convenient for them, communicating in a way that

meets their cognitive and linguistic needs, and considering their stage of recovery when developing a treatment plan. Meeting persons served where they are also means tailoring services and approaches to align with the cultural identity of the person served. The term "culture" in this context, should not be limited to race and ethnicity, but should also extend to other cultural identities, including but not limited to: former foster youth, persons with disabilities, gender, LGBTQ persons, and persons with religious and spiritual affiliations.

Linkage to housing opportunities must be provided to the person served based on their need and level of recovery. The ultimate housing goal for each person served should be safe, affordable, and permanent housing. Contractor is expected to follow the Department of Behavioral Health (DBH) process for accessing housing options for persons served. FSP funds may not be used to pay for Housing Interventions.

III. TARGET POPULATION

The target population eligible for services under this Agreement includes adults eighteen (18) years or older who meet specialty mental health criteria, present with severe impairment, persons over eighteen (18) but under twenty-one (21) with a diagnosable SED as set forth in the California Welfare and Institutions Codes, section 5600.3(a), or persons served who have a co-occurring moderate to severe SUD.

In addition, significant support persons involved in the well-being of the person enrolled in services may receive FSP ICM and OP SMHS from this program, as clinically appropriate and medically necessary, while the identified person served is enrolled, to optimize the person's ability to reach wellness and recovery. Persons served (including any significant support persons receiving SMHS must be enrolled, disenrolled, and/or re-enrolled in the electronic health record (EHR) program listing that aligns with the level of care in which they are receiving services (either FSP ICM or OP), as that level changes.

Eligible children and youth means persons who are twenty-five (25) years of age or under who meet the following:

- Meet SMHS access criteria specified in subdivision (d) of W&I Code section 14184.402 and implemented in SMHS guidance in Behavioral Health Information Notice (BHIN) 26-002 (includes individuals twenty-one (21) – twenty-five (25) years of age who meet this criteria), including BHIN Enclosure 1, DHCS Approved Youth Trauma Screening Tools, including any subsequent updates

Eligible adults and older adults mean persons who are twenty-six (26) years of age or older who meet the following:

- Meet SMHS access criteria specified in subdivision (c) of W&I Code section 14184.402 and implemented in SMHS guidance in BHIN 26-002 (only applies to individuals twenty-six (26) years of age and older), including any subsequent updates

A. Entry Criteria for FSP ICM Level Services
Identified persons served shall meet the following criteria for FSP level services:

1. Be an eligible adult or older adult with an SMI or co-occurring SMI/SUD who meet the criteria above.
2. Be an eligible child or youth with an SED, which includes transitional age youth (TAY).
3. Meet one of the priority population criteria specified in WIC, section 5892, subdivision (d).

   For children and youth the priority populations are:

   a. Chronically homeless or experiencing homelessness or at risk of homelessness
   b. In, or at risk of being in, the juvenile justice system
   c. Re-entering the community from a youth correctional facility
   d. In the child welfare system pursuant to WIC sections 300, 601, and 602
   e. At risk of institutionalization

   For adults and older adults the priority populations are:

   a. Chronically homeless or experiencing homelessness or at risk of homelessness
   b. In, or at risk of being in, the justice system
   c. Re-entering the community from a state prison or county jail
   d. At risk of conservatorship
   e. At risk of institutionalization
4. Persons selected for participation in the FSP Service Category must meet the eligibility criteria based on age group as found in California Code, WIC 5600.3.
5. Referrals to the FSP level services of FSP ICM shall be reviewed and approved by Fresno County DBH prior to program enrollment.
6. For FSP ICM, eligible persons served must have:
   a. A current or suspected Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis consistent with a SMI, SED, or co-occurring SMI and SUD. Individuals with a primary diagnosis of intellectual/developmental disabilities (I/DD) are not appropriate for FSP ICM.
   b. A moderate to significant functional impairment. Moderate to significant means that the impairment might be consistently problematic or that the impairment is occasionally significant (but the individual experiences more stability MOST of the time). Functional impairment can include:
      i. Difficulty performing practical daily tasks needed to function in the community such as maintaining personal hygiene, meeting nutritional needs, caring for personal business affairs, obtaining medical, legal and housing services, recognizing and avoiding common dangers or hazards to oneself and one's possessions;
      ii. Persistent or recurrent difficulty performing daily living tasks, except with moderate support or help from others such as friends, family or relatives;
      iii. Difficulty maintaining consistent employment at a self-sustaining level or to carry out homemaker roles; and/or
      iv. Difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

c. An indicator of continuous moderately high service needs or relatively low service needs with occasional periods of high-service needs, as evidenced by one or more of the following:
   i. Risk of hospitalization or crisis/emergency care without this service;
   ii. Risk of returning to unsheltered homelessness after being placed in interim housing, or risk of returning to homelessness after being placed in permanent supportive housing without this service.
   iii. Intractable (persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
   iv. Co-existing SUD of significant duration;
   v. High-risk or a recent history of being involved in the criminal justice system;
   vi. Living in substandard housing, experiencing homelessness, or at imminent risk of becoming homeless;
   vii. Living in housing, but clinically assessed to need more intensive services to maintain housing;
   viii. Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided; and/or
   ix. Inability to participate in traditional office-based services.

B. Entry Criteria for Outpatient Level Services
Persons shall meet SMHS eligibility criteria for OP as found in BHIN 26-002. Treatment services in the OP level of care focuses primarily on therapeutic appointments with occasional community case management services. Persons at this level of care have achieved some stability in their severe mental illness yet still require SMHS.

IV. DESCRIPTION OF SERVICE DELIVERY MODELS

A. Services Start Date: July 1, 2026

B. Summary of Services
Contractor shall provide a continuum of care, including the following high-intensity service models: FSP ICM and OP. The expectations for each level of care are detailed below. While the service components may be the same or similar across ACT and FSP ICM, service delivery should be appropriately tailored based on level of care provided. In addition, the level of intensity of crisis services varies across ACT and FSP ICM. Contractors without an ACT team must provide referral and linkage to a contracted ACT provider.

Full-Service Partnership (FSP) programs provide individualized, team-based care to persons served living with significant behavioral health needs through a “whatever it takes” approach. Persons served benefit from a community-based, whole-person approach that is trauma-informed, recovery-focused, age-appropriate and delivered in partnership with families or an individual’s natural supports.

FSPs provide the full spectrum of community services necessary to attain identified goals, as well as any services that may be deemed necessary through collaborative

planning between the County, the person served and/or their family to address unforeseen circumstances in the person's life. Each person served must have a Personal Services Coordinator (PSC) who acts as an ally and a "single point of responsibility" for the person served.

The FSP program services shall be provided utilizing the BHSA Policy Manual and the Evidence-Based Practices (EBPs) Policy Manual which is available at: https://policy-manual.mes.dhcs.ca.gov/behavioral-health-services-act-county-policy-manual/LIVE/.

Contractor will adhere to FSP regulations, which can be found in their entirety in the California Code of Regulations, Title 9, Sections 3620, 3620.05 and 3620.10 which are available at: https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I4F8301404C6B11EC93A8000D3A7C4BC3&transitionType=Default&contextData=%28sc.Default%29.

1. For all levels of care:
    a. Contractor must have the capability of supporting persons in need of co-occurring SUD treatment services in addition to SMHS. Refer to the service descriptions below for minimum requirements by service model.
    b. Provide appropriate age, culture, gender, sexual identity, and language services and accommodations for physical disabilities to persons served.
    c. Make appropriate referrals and linkages to services that are beyond that of the Contractor's services. Contractor shall continue to coordinate services with any other community mental health, SUD, and non-mental health providers as well as other medical professionals. Methods for service coordination and communication between Contractor and other service providers for each person served shall be developed and implemented consistent with Fresno County confidentiality rules.
    d. Provide support to the family of the person served and other members of the person's social network to help them support the person in managing symptoms and illness and reduce family and social stress associated with the illness.
    e. Assist person served/family with accessing all entitlements or benefits for which they are eligible (i.e., Medi-Cal, Supplemental Security Income (SSI), Section 8 vouchers, etc.).
    f. Develop family support and involvement whenever possible.
    g. Refer persons to supported education and employment opportunities, as appropriate.
    h. Provide or link to transportation services to access necessary support services or gain entitlements or benefits.
    i. Provide and claim for peer support activities, as appropriate.
    j. Ensure that clinically appropriate Evidence-Based Practices (EBP) are utilized to fidelity in service delivery.
    k. Ongoing clinical assessment of the mental health and SUD symptoms of the person served and their response to treatment.

l. Provide services in the areas of medication evaluation, prescription, administration, monitoring, and documentation via in-person or telepsychiatry, including all psychiatric medications that are considered the standard of care in management of serious psychiatric conditions.
m. Educate the person served regarding their mental illness and the effects (including side effects) of prescribed medications.
n. Provide symptom management skills and help the person served identify the symptoms and their occurrence patterns, and develop methods (internal behavioral, adaptive) to lessen their effects.
o. Provide, both planned and on an “as needed” basis, psychological support as is necessary to help person served accomplish their personal goals and cope with the stresses of day-to-day living.
p. Assist persons to locate appropriate housing in the community.
q. Provide training, instruction, support, and assistance to the person served in developing personal skills such as personal hygiene, housekeeping, money management skills, use of community transportation, and to locate, finance and maintain safe, clean and affordable housing.
r. Develop and support the participation of the person served in social interactions, including, when possible, recreational social activities, and relationships. Priority shall be given to supporting persons served in establishing positive social relationships in normative community settings.
s. Act to minimize the involvement of the person served in the criminal justice system.
t. Assist the person served, family and other members of their social network to relate in a positive and supportive manner.
u. Monitor service outcomes to determine if the person served has meaningful use of their time, stays in school, maintains employment, has reduced numbers of hospitalizations, incarcerations, and periods of homelessness. DBH will use State-identified criteria for measuring these outcomes. The treatment services will be monitored to ensure appropriate service delivery and adherence to BHSA and other State regulations.
v. Provide comprehensive services, including intensive mental health treatment, rehabilitation, case management, and peer support with the goal of increasing adaptive functioning in the community and preventing unnecessary re-admissions to Institutes of Mental Disease (IMD), acute inpatient facilities, or other higher levels of care.
w. Assist the person served in accessing and participating in the employment and education programs offered in the community, as appropriate.
x. Assist persons served in accessing housing options and assist persons served in maintaining a stable residence by providing needed services, accessing resources, and encouraging persons served to be independent, productive, and responsible.
y. Services, publications, and buildings will be fully accessible to meet the physical and linguistic abilities of all persons served. Contractor must have the availability of language assistance for persons served when their language of choice is not

available through existing staff. At a minimum, Contractor must offer interpreter services either in-person or through a contract with a language line provider.

z. Be responsible for developing a plan to continually engage targeted populations through outreach and engagement services. Contractor shall distribute literature and informational brochures in appropriate languages and request feedback as to how access to care could be improved for the intended population. Contractor will be expected to collaborate with agencies that are recognized and accepted by the target population.

aa. Comply with the documentation requirements established in BHIN 23-068, or subsequent updated guidance, which includes standardized assessment requirements; dynamic problem list; progress notes; and care planning.

bb. Deliver a comprehensive specialty mental health program. Contractor must ensure the following services are provided by appropriately credentialed staff:
   i. Assessment
   ii. Crisis Intervention
   iii. Medication Support Services
   iv. Peer Support Services
   v. Psychosocial Rehabilitation
   vi. Referral and linkages
   vii. Therapy
   viii. Treatment Planning
   ix. SUD referral and linkage process for FSP ICM

2. Full-Service Partnership Intensive Case Management (FSP ICM)
FSP ICM offers a comprehensive array of community-based services and can be provided either as a step-down from ACT or as an intervention to avert the need for ACT-level care. FSP ICM is delivered by a multidisciplinary team that incorporates core case management functions – such as assessment, planning, and linkage – with low staff-to-client ratios, assertive outreach, and direct service delivery, including peer services, crisis intervention, psychosocial rehabilitation, psychotherapy, medication management and more. FSP ICM is for individuals who may not meet ACT eligibility criteria but still have significant behavioral health needs and can benefit from FSP supports.

Typically, a person at this level of care would receive at least one (1) contact per week, or more as clinically appropriate, with most contacts being face-to-face/in-person. Telehealth may be used judiciously for visits that exceed the once per week threshold. The actual type and frequency of FSP ICM contacts should be determined based on the needs of each individual and the intensity of the service may be higher than four (4) contacts per month. Persons who do not require this frequency of contacts and in-person engagement are typically better suited for OP. Contractor is responsible for transitioning the person served to OP.

The annual maximum FSP ICM census for the program shall not exceed the following for each fiscal year of the Agreement:

FY 2026-27	200

FY 2027-28	250
FY 2028-29	300
FY 2029-30	325

FSP ICM is a self-contained, team-based service. FSP ICM teams shall:

a. Provide whatever direct assistance is necessary and reasonable, including linkages, to ensure that the person served obtains the basic necessities of daily life, such as food, housing, transportation, clothing, medical and dental services.
b. Provide services based on individual needs and may refer individuals to additional services the team cannot provide such as crisis services, supported employment, and care for co-occurring SUDs.
c. Be comprised of a mix of full-time and part-time team members.
d. Provide persistent and committed engagement to lower acuity individuals.
e. Provide integrated, time-unlimited service delivery.
f. Ensure that each FSP ICM team member shall have access to an adequate amount of financial resources to make emergency purchases of food clothing, prescriptions, transportation, or other items for person served, as needed, during regular working hours. The team shall have access to larger flexible funding accounts for assistance with furniture purchases and other items, with sound accounting practices for recording and monitoring the use of these funds to prevent fraud, waste and abuse. Contractor will collaborate with County in detailed categorizing of all expenditures.
g. Assist the person served with establishing a payee or payee services, as needed. The FSP ICM team may utilize person served assistance funds to assist person served with short-term loans or grants, as necessary. The team shall link persons served to appropriate social services, provide transportation as necessary, and link the person served to appropriate legal advocacy representation.

3. Outpatient (OP)
   Persons at this level of care have achieved some stability in their severe mental illness yet still require SMHS. Persons served at this level shall receive a minimum of one (1) contact per week with at least one (1) face-to-face contact per month. This can include but is not limited to individual therapy, group therapy, rehabilitation, case management, peer support services, and medication management. In the OP level of care, treatment focuses primarily on therapeutic appointments with occasional community case management and medication services.

   Outpatient services are funded by Medi-Cal fee for service and persons served at this level of care are not eligible to receive additional supports through the Whatever It Takes activity.

C. MH and SUD Co-Occurring Capabilities
   Co-occurring capability involves embedding integrated policies, procedures, practices and training in the program to make it routine for clinicians to successfully deliver integrated care. FSP programs are required to:

1. Conduct American Society of Addiction Medicine (ASAM) screenings as part of an integrated assessment upon intake into the FSP.
2. FSP ICM programs must have a referral mechanism in place to link persons served to necessary SUD services. ACT teams are expected to obtain a release of information (ROI) from person served to facilitate treatment collaboration and care coordination with the SUD treatment program.
3. Offer medications for addiction treatment (MAT) services directly or have an effective referral process in place.
4. Have memoranda of understanding (MOUs) with SUD providers to link persons served with outpatient, residential and MAT services.

D. Individual Placement and Support (IPS) Model of Supported Employment
The IPS model of Supported Employment is an evidence-based intervention that engages persons served living with significant behavioral health needs in finding and maintaining competitive employment, which can play a crucial role in their recovery and integration into the community. IPS provides structure, purpose, and social connection and is shown to reduce isolation and combat stigma for persons served living with mental health conditions.

Contractor must make IPS services available in conjunction with other FSP service models such as FSP ICM to offer a comprehensive approach to recovery that addresses both clinical and functional needs.

To meet this requirement, Contractor must enter into a memorandum of understanding (MOU) with County's current contracted IPS provider to facilitate referrals and engagement in IPS services. The MOU must define the responsibilities of Contractor and the IPS provider in the referral and engagement process for persons served. The executed MOU must be provided to County.

E. Non-Medi-Cal Services and Supports (Whatever It Takes)
The "whatever it takes" (WIT) approach refers to the commitment to provide comprehensive, low barrier, individualized, and flexible support services to help persons served with serious mental illness, including those with a co-occurring SUD, to achieve stability, recovery and reach their wellness goals. FSP programs are designed to remove barriers that prevent individuals from engaging in treatment, reaching recovery and maintaining their wellness. The "whatever it takes" model requires that all services and supports are individualized and directly aligned with the person's wellness and recovery goals.

WIT funds, made available under this agreement, shall not be used for housing (rent, deposits, etc.) or activities and supports available under the community supports provided by the Medi-Cal Managed Care Plans (MCPs), which include Anthem Blue Cross, CalViva Health and Kaiser Permanente.

Contractor must keep record of items purchased under this service category to account for expenditures and must have policies and procedures in place to prevent fraud, waste and abuse.

F. Outreach and Engagement

Outreach and engagement shall refer to the active, persistent and person-centered efforts to identify and/or locate, engage, enroll and retain persons served who meet FSP-level criteria, but who are not currently connected or actively receiving behavioral health services.

Outreach and engagement must commence as soon as possible following the receipt of a referral. The number of outreach and engagement attempts, and the length of time it takes to engage a person served, will vary depending on the unique circumstances of the person served. For example, physical health, hospitalization, incarceration and current mental health may be factors that delay engagement. Provider shall make repeated attempts to contact persons served, in the method most likely to result in engagement and enrollment of the person served.

Acceptable outreach activities include, but are not limited to:

1. Field-based outreach, including visits to homes, shelters, public areas/streets where the person served is known to spend time, hospitals, schools, jails, and community settings;
2. Telephone calls;
3. Electronic messaging (text and email), if the person served is known to have access to electronic messaging; and
4. In collaboration with community partners to coordinate care.

G. Location of Services

1. Services shall be provided at the following clinic location(s):

   2549 West Shaw Avenue, Fresno CA 93711

2. In addition to these locations, services for each level of care shall be provided in primarily field-based locations as determined to be appropriate for the person served.

3. FSP ICM

   FSP ICM level services shall be primarily provided within the community as opposed to services being performed at traditional clinical offices to increase the likelihood of persons served accepting services, as some persons served may be reluctant to seek services provided in traditional mental health settings. FSP ICM services can be delivered in the home, community, school, or other community-based settings as determined in collaboration with all relevant parties. Locations must provide easy access for the person served. Contractor should follow best practices and exercise clinical judgement to maintain confidentiality and will be responsible for obtaining any releases for disclosure to third parties necessary to gain access.

Telehealth, mobile services, and co-location in natural supports and gathering places for the intended population are additional options to increase the frequency of persons served obtaining needed services.

For office-based hours, Contractor must provide the hours of highest need for this target population. Contractor should have a plan for transportation or access to services for this target population. Services shall be delivered wherever the intended target population resides, throughout Fresno County.

4. Outpatient (OP)
   Contractor shall provide Field-based and/or Clinic-based service delivery for OP level services as needed. Contractor should have a written plan to explain how OP level services would be provided with the following understanding of the difference between Field-based and Clinic-based service delivery:

   Clinic-based service delivery means less than fifty percent (50%) of services are in the field. Field-based service delivery are services that do not occur through telehealth and do not occur in designated sites in which the contractor is afforded regular access. Designated sites shall be identified by Contactor within their written plan.

H. Hours of Operation

   Standard Office hours are Monday - Saturday 7:00 a.m. - 7:00 p.m.

I. Schedule of Services
   The hours of operation must ensure availability to persons served and their families, as needed. A minimum of eight (8) hours, five (5) days per week is required for routine operations. Should persons served or their family members require services during non-traditional office hours, Contractor will work to accommodate their needs in the most appropriate person-centered manner. Contractor shall provide accommodation for services outside of traditional business hours. The County strongly recommends the following standard office hours of Monday through Saturday from 7:00 AM – 7:00 PM.

   Additionally, Contractor shall be expected to temporarily extend office hours, as needed, to accommodate and improve timeliness of services as needed.

J. Length of Stay
   Length of stay in each level of care shall be determined based on eligibility criteria, and the clinical needs and progress of the persons served.

   Contractor shall ensure periodic evaluation of persons served for appropriate placement or movement to another level of care. Contractor shall coordinate with DBH to ensure continuing eligibility for persons served.

K. Referral Sources and Referral Process

Referrals can be made from various sources, including but not limited to community physical and behavioral health providers, school representatives, the child welfare system, or the justice system. The determination of persons served entry into ACT and FSP ICM programs shall be made by the County. Contractor can receive and admit referrals for OP without DBH approval. If a person served is admitted to OP and is later determined to need ACT or FSP ICM levels of care, the provider must submit a referral to the County and receive approval before transitioning the identified person to the higher level of care.

Contractor must ensure that referrals received are processed in a timely manner, with no waitlist for services.

L. Care Coordination/Transition Plan

1. Intake and Initial Assessment
   Contractor shall follow their established plans to process referrals and begin the intake process within the timeliness standards outlined below, including a plan for outreach and engagement activities as needed.

   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 shall be completed within a clinically appropriate timeframe. If the timeframe exceeds thirty (30) days, justification for this delay shall be clearly represented in the clinical documentation.

2. Transition and Discharge
   Contractor shall ensure that transition and discharge procedures are supportive, minimally disruptive, and clinically appropriate.

   Persons referred for services may be denied services if the referred person does not meet medical necessity for specialty mental health services, with or without a co-occurring SUD, or meets medical necessity for a mental health diagnosis that is not covered by the County's MHP. Persons who are determined to be ineligible for services shall be assessed and linked to the appropriate level of care or care delivery system.

   Persons served shall be transitioned between levels of care within the program as clinically appropriate. Transitional supports shall be provided (i.e., a warm handoff) to ensure that persons served are appropriately linked and engaged in services before terminating services from the program.

   Discharge is determined on a case-by-case basis, as clinically appropriate. Reasons for discharge include: the person served, or caregiver refuses or terminates services; the person served is transferred to another program mutually agreed upon by the treatment team, person served (and their guardian, if applicable) agrees that the treatment goals have been met.

M. Level of Care/Modality

Persons served will be assigned to one of the following levels of care, as appropriate, upon completion of the intake/assessment:

1. Full-Service Partnership Intensive Case Management (FSP ICM)
   Persons served in the FSP ICM level of care benefit from a comprehensive array of community-based services, including a "Whatever It Takes" approach, that incorporate core case management functions. Persons served at this level receive a minimum of one (1) contact per week, or more as clinically appropriate, with at least one of those contacts being face-to-face each month.
   a. Caseload: 1:25 per FSP ICM team member
   b. Contractor will collaborate with DBH to evaluate program census and staffing.
   c. Length of Stay: Suggested length of stay is eighteen (18) to twenty-four (24) months, with the assigned provider evaluating the needs of each person served on an ongoing basis to ensure that the level of care is clinically appropriate.

2. Outpatient (OP)
   Persons served in the OP level of care benefit from therapeutic appointments for individual/group treatment, and case management and medication services, as needed. Persons served at this level receive a minimum of one (1) contact per week with at least one (1) face-to-face contact per month.

   Length of stay for persons served in an outpatient program is suggested to be twelve (12) to eighteen (18) months with assigned provider evaluating the needs of each person served on an ongoing basis to ensure that the level of care is clinically appropriate.

N. Evidence-Based Practices (EBPs)
   Contractor shall cooperate with DHCS-established Centers of Excellence (COE) which will offer training, technical assistance and fidelity monitoring to behavioral health delivery systems and behavioral health practitioners implementing EBPs.

   1. Contractor shall utilize additional EBPs and interventions to offer clinically appropriate, unduplicated services and maintain fidelity to the program model, including provision of psychiatric services.
   2. Contractor must be prepared to utilize EBPs throughout their programming as clinically appropriate, to employ harm reduction and strength-based approaches.
   3. FSP ICM programs: Submit to DBH a list of the EBPs that will be used in the program. DBH will review and approve the EBPs for this level of care and Contractor shall ensure the use of the EBPs is documented in treatment.
      a. Examples of EBPs include but are not limited to:
         i. Motivational Interviewing (MI)
         ii. Seeking Safety (SS)
         iii. Cognitive Behavioral Therapy (CBT)
         iv. Dialectical Behavior Therapy (DBT)
         v. Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Other evidence-based practice models recognized as effective in improving functioning of the target population, and as befitting the Contractor's program vision may also be utilized if deemed appropriate.

4. County Shall:
   a. Assist Contractor's efforts to evaluate the needs of each person served on an ongoing basis to ensure that the level of care they are receiving is clinically appropriate.
   b. Provide oversight and collaborate with Contractor 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 DHCS and/or other oversight agencies in regard to program administration and outcomes.
   c. Assist Contractor in making linkages with the behavioral 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 Contractor for ongoing consultation.
   e. Gather outcome information from target person served groups and Contractor throughout each term of this Agreement. County shall notify Contractor when their participation is required. The performance outcome measurement process shall not be limited to survey instruments but will also include, as appropriate, person served and staff interviews, chart reviews, data analysis and other methods of obtaining required information. To comply with changing regulations, outcome and data tracking requirements are expected to change and County will inform and work with the Contractor to adapt throughout the term of this agreement.
   f. Assist Contractor's efforts toward cultural and linguistic responsiveness by providing technical assistance regarding cultural responsiveness requirements.

5. Staffing
   Contractor shall utilize appropriate staffing plans/patterns sufficient to deliver the necessary levels of services and the volume of services necessary to meet the community's need. Clinical Supervisors and the clinical training program must meet the California Board of Behavioral Sciences and/or California Board of Psychology standards.

   Contractor will be encouraged to hire and recruit those with lived experience including persons served or their family members that have previously received behavioral health services. Peer support services are required as part of the program design.

6. Contractor Shall:
   a. Ensure staffing is appropriate for the high-intensity services models implemented.
   b. Have a job classification describing responsibilities, including supervision and team lead duties.
   c. At a minimum, have FSP ICM teams that include the following:

i. FSP ICM teams are required to have a team lead, and should include a combination of part-time and full-time providers for a total of eight (8) to ten (10) staff such as:
   - Prescribers
   - LPHA (team lead)
   - Certified Peer support specialists
   - Registered Nurses, Licensed Vocational Nurses, Licensed Psychiatric Practitioners
   - Other qualified providers

d. Ensure all contacts with persons served are delivered with appropriate clinical oversight and supervision.
e. Provide a sufficient number of licensed staffing and manage assignment of persons served within the program to ensure that all services for persons with dual coverage are claimable (e.g. Medicare/Medi-Cal dually enrolled persons).
f. Consider the linguistic and cultural needs of the community when recruiting for all positions, as well as personal and professional experiences.
g. Maintain an up-to-date caseload record of all persons enrolled in services, and provide person, programmatic, and other demographic information to the County.
h. Ensure each enrolled person served is assigned to a Personal Service Coordinator, meet the community needs, ensure the program has no waitlists and keep referrals open at all times.
i. Require staff members working directly with persons served to provide outreach outside of the office setting and have the capacity to provide as many contacts as needed with persons served to meet their recovery/resiliency and wellness goals.
j. Have a plan for how they will minimize staff turnover and cultivate staff retention. Contractor will also do salary market research to assure competitive salaries for positions to curb staff turnover.
k. Offer Peer Support resources:
   BHSA funding incorporates a person served/family-focused peer support component that enhances bi-cultural and bilingual peer-centered services. Services will include but not be limited to: support groups, one-on-one assistance, linkages with a peer navigator, and support. The ISSP can include the use of Peer Support resources. Peer support services are Medi-Cal billable when the Peer Support Specialist has completed the County-approved Peer Support Specialist Training and has received their certification, and the designated supervisor has completed the County-approved Peer Support Supervisor training.
l. Ensure staff meet required trainings and training expectations.
   Contractor's employees, volunteers, interns, and student trainees or subcontractors of Contractor, in each case, are expected to perform professional services per an agreement with County. Contractor will comply with the training requirements and expectations referenced in Exhibit B, Attachment D, Training Requirements Reference Guide.

   Trainings are to be completed by Contractor's staff after contract execution, in a timely manner. Completion deadlines for trainings are listed in Revised Exhibit B, Attachment D within the descriptions. Additionally, the execution of a new

contract does not restart the timeline for required trainings for staff. If staff have recently completed a training under another contract, it will be accepted.

FRESNO COUNTY BEHAVIORAL HEALTH REQUIREMENTS

I. General Requirements

a. **Guiding Principles**. Contractor shall align programs, services, and practices with the vision, mission, and guiding principles of the DBH, as further described in Exhibit B – Attachment A to this Agreement, titled "Fresno County Department of Behavioral Health Guiding Principles of Care Delivery".

b. **Rights of Persons Served**. Contractor shall post signs informing persons served of their right to file a complaint or grievance, appeals, and expedited appeals. In addition, Contractor shall inform every person served of their rights as set forth in Exhibit B – Attachment B to this agreement, titled "Fresno County Behavioral Health Plan Rights of Persons Served".

c. **Records.** Contractor shall maintain records in accordance with Exhibit B – Attachment C to this Agreement, titled "Documentation Standards for Persons Served Records". All records of the person served shall be maintained for a minimum of ten (10) years from the date of the end of this Agreement.

d. **Licenses/Certificates**. Throughout the term of this Agreement, Contractor and Contractor's staff shall maintain all necessary licenses, permits, approvals, certificates, waivers and exemptions necessary for the provision of the services hereunder and required by the laws and regulations of the United States of America, State of California, the County of Fresno, and any other applicable governmental agencies. Contractor shall notify County immediately in writing of its inability to obtain or maintain such licenses, permits, approvals, certificates, waivers and exemptions irrespective of the pendency of any appeal related thereto. Additionally, Contractor and Contractor's staff shall comply with all applicable laws, rules or regulations, as may now exist or be hereafter changed.

e. **Organizational Provider.** Contractor shall maintain requirements as a Behavioral Health Plan (BHP) organizational provider throughout the term of this Agreement. If for any reason, this status is not maintained, County may terminate this Agreement pursuant to Article 6 of this Agreement.

f. **Staffing.** Contractor agrees that prior to providing services under the terms and conditions of this Agreement, Contractor shall have staff hired and in place for program services and operations or County may, in addition to other remedies it

may have, suspend referrals or terminate this Agreement, in accordance to Article 6 of this Agreement.

g. **Training.** Contractor agrees that its employees, volunteers, interns, and student trainees or subcontractors of Contractor, in each case, are expected to perform professional services per an agreement with County. Contractor will comply with the training requirements and expectations referenced in Exhibit B – Attachment D to this Agreement, titled "Fresno County Department of Behavioral Health Contractor Training Requirements Reference Guide".

h. **Credentialing and Recredentialing.** Each individual Contractor staff shall not provide any specialty mental health services without an approved credentialing application from County. Contractor and their respective staff must follow the uniform process for credentialing and recredentialing of service providers established by County, including disciplinary actions such as reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of an individual or provider.

Upon request, the Contractor must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.

Contractor must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. See section III below.

Contractor is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.

i. **Criminal Background Check.** Contractor shall ensure that all providers and/or subcontracted providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. § 455.434(a).

Contractor shall provide evidence of completed consents when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).

j. **Clinical Leadership.** Contractor shall send to County upon execution of this Agreement, a detailed plan ensuring clinically appropriate leadership and supervision of their clinical program. Recruitment and retaining clinical leadership with the clinical competencies to oversee services based on the level of care and program design presented herein shall be included in this plan. A description and monitoring of this plan shall be provided.

k. **Additional Responsibilities**. The parties acknowledge that, during the term of this Agreement, the Contractor will hire, train, and credential staff, and County will perform additional staff credentialing to ensure compliance with State and Federal regulations, if applicable.

l. **Subcontracts**. Contractor shall obtain written approval from County's Department of Behavioral Health Director, or designee, before subcontracting any of the services delivered under this Agreement. County's Department of Behavioral Health Director, or designee, retains the right to approve or reject any request for subcontracting services. Any transferee, assignee, or subcontractor will be subject to all applicable provisions of this Agreement, and all applicable State and Federal regulations.

Contractor shall be held primarily responsible by County for the performance of any transferee, assignee, or subcontractor unless otherwise expressly agreed to in writing by County's Department of Behavioral Health Director, or designee. The use of subcontractors by Contractor shall not entitle Contractor to any additional compensation that is provided for under this Agreement.

m. **Reports**. The Contractor shall submit the following reports and data:

   i. **Outcome Data.** Contractor shall submit to County program performance outcome data, as requested. Outcome data and outcome requirements are listed in Exhibit B – Attachment E to this Agreement, titled "Program Outcomes and Performance Measurements". Outcome data and outcome requirements are subject to change at County's discretion.

   ii. **Additional Reports.** Contractor shall also furnish to County such statements, records, reports, data, and other information as County may request pertaining to matters covered by this Agreement. In the event that

Contractor fails to provide such reports or other information required hereunder, it shall be deemed sufficient cause for County to withhold monthly payments until there is compliance. In addition, Contractor shall provide written notification and explanation to County within five (5) days of any funds received from another source to conduct the same services covered by this Agreement.

n. **Timely Access.** It is the expectation of the County that Contractor provide timely access to services that meet the State of California standards for care. Contractor shall track timeliness of services to persons served and provide a monthly report showing the monitoring or tracking tool that captures this data. County and Contractor shall meet to go over this monitoring tool, as needed but at least on a monthly basis. County shall take corrective action if there is a failure to comply by Contractor with timely access standards.

o. **Compliance with Behavioral Health Specific Laws.**

   i. Contractor shall provide services in conformance with all applicable State and Federal statutes, regulations and sub regulatory guidance, as from time to time amended, including but not limited to:

      1. California Code of Regulations, Title 9;
      2. California Code of Regulations, Title 22;
      3. California Welfare and Institutions Code, Division 5;
      4. United States Code of Federal Regulations (CFR), Title 42, including but not limited to Parts 438 and 455;
      5. United States CFR, Title 45;
      6. United States Code, Title 42 (The Public Health and Welfare), as applicable;
      7. Balanced Budget Act of 1997;
      8. Health Insurance Portability and Accountability Act (HIPAA); and
      9. Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as Behavioral Health Information Notices (BHINs), Mental Health and Substance Use Disorder Services Information Notices (MHSUDS INs), and provisions of County's, state or federal contracts governing services for persons served.

ii. In the event any law, regulation, or guidance referred to in this section is amended during the term of this Agreement, the parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

iii. Contractor recognizes that County operates its behavioral health programs under an agreement with DHCS, and that under said agreement the State imposes certain requirements on County and its subcontractors. Contractor shall adhere to all State requirements, including those identified in Exhibit B – Attachment F to this Agreement, titled "State Behavioral Health Requirements".

p. **Meetings**. Contractor shall participate in monthly, or as needed, workgroup meetings consisting of staff from County's DBH to discuss service requirements, data reporting, training, policies and procedures, overall program operations and any problems or foreseeable problems that may arise. Contractor shall also participate in other County meetings, such as but not limited to quality improvement meetings, provider meetings, audit meetings, Behavioral Health Board meetings, bi-monthly contractor meetings, etc. Schedule for these meetings may change based on the needs of the County.

q. **Monitoring**. Contractor agrees to extend to County's staff, County's DBH and the California Department of Health Care Services (DHCS), or their designees, the right to review and monitor records, programs, or procedures, at any time, in regard to persons served, as well as the overall operation of Contractor's programs, in order to ensure compliance with the terms and conditions of this Agreement.

r. **Electronic Health Record**. Contractor shall maintain its records in County's EHR system in accordance with Exhibit B – Attachment G, "Electronic Health Record Requirements and Service Data", free of charge as licenses become available. The person served record shall begin with registration and intake, and include person served authorizations, assessments, plans of care, and progress notes, as well as other documents as approved by County. County shall be allowed to review records of all and any services provided. If Contractor determines to maintain its records in the County's EHR, it shall provide County's DBH Director, or designee, with a thirty (30) day notice. If at any time Contractor chooses not to maintain its records in the County's EHR, it shall provide County's DBH Director,

or designee, with thirty (30) days advance written notice and Contractor will be responsible for obtaining its own system, at its own cost, for electronic health records management.

Disclaimer

County makes no warranty or representation that information entered into the County's DBH EHR system by Contractor will be accurate, adequate, or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized access, viewing, use, disclosure, or breach. Contractor is solely responsible for person served information entered by Contractor into the County's DBH EHR system. Contractor agrees that all Private Health Information (PHI) maintained by Contractor in County's DBH EHR system will be maintained in conformance with all HIPAA laws, as stated in section VIII, "Federal and State Laws."

s. **Generative Artificial Intelligence Technology Use & Reporting**
    i. During the term of this Agreement, Contractor must notify the County in writing if their services or any work under this Agreement includes, or makes available, any Generative Artificial Intelligence (GenAI) technology, including GenAI from third parties or subcontractors.
        1. Contractor's notification must include:
            a. The name and description of the GenAI tool used.
            b. The purpose and manner in which the GenAI tool is used in performing services under this Agreement.
            c. The safeguards and controls in place to ensure data security, confidentiality and compliance with applicable laws and regulations.
    ii. Contractor must also notify the County of any new or previously undisclosed GenAI technology introduced before and during the term of this Agreement. At the direction of the County, Contractor shall discontinue the use of any GenAI technology used in the service or any work under this agreement that materially impacts functionality, risk, or contract performance until such use has been reviewed by the County

t. **Confidentiality.**

i. The County and the Contractor may have access to information that the other considers to be a trade secret as defined in California Government Code section 7924.510(f).

ii. Each party shall use the other's Information only to perform its obligations under, and for the purposes of, the Agreement. Neither party shall use the Information of the other Party for the benefit of a third party. Each Party shall maintain the confidentiality of all Information in the same manner in which it protects its own information of like kind, but in no event shall either Party take less than reasonable precautions to prevent the unauthorized disclosure or use of the Information.

iii. The Contractor shall not disclose the County's data except to any third parties as necessary to operate the Contractor Products and Services (provided that the Contractor hereby grants to the County, at no additional cost, a non-perpetual, noncancelable, worldwide, nonexclusive license to utilize any data, on an anonymous or aggregate basis only, that arises from the use of the Contractor Products and Services by the Contractor, whether disclosed on, subsequent to, or prior to the Effective Date, to improve the functionality of the Contractor Products and Services and any other legitimate business purpose, subject to all legal restrictions regarding the use and disclosure of such information).

iv. Upon termination of the Agreement, or upon a Party's request, each Party shall return to the other all Information of the other in its possession. All provisions of the Agreement relating to confidentiality, ownership, and limitations of liability shall survive the termination of the Agreement.

v. All services performed by the Contractor shall be in strict conformance with all applicable Federal, State of California, and/or local laws and regulations relating to confidentiality, including but not limited to, California Civil Code, California Welfare and Institutions Code, California Health and Safety Code, California Code of Regulations, and the Code of Federal Regulations.

u. **Physical Accessibility.** In accordance with the accessibility requirements of section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973, Contractor must provide physical access, reasonable accommodations,

and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities.

v. **Publicity Prohibition.**

i. **Self-Promotion.** None of the funds, materials, property, or services provided directly or indirectly under this Agreement shall be used for Contractor's advertising, fundraising, or publicity (i.e., purchasing of tickets/tables, silent auction donations, etc.) for the purpose of self-promotion.

ii. **Public Awareness.** Notwithstanding the above, publicity of the services described in Exhibit A of this Agreement shall be allowed as necessary to raise public awareness about the availability of such specific services when approved in advance by County's DBH Director or designee. Communication products must follow DBH branding standards, including typefaces and colors, to communicate our authority and project a unified brand. This includes all media types, platforms, and all materials on and offline that are created as part of DBH's efforts to provide information to the public.

w. **Child Abuse Reporting Act.**

i. Contractor shall establish a procedure acceptable to the County's DBH Director, or designee, to ensure that all of the Contractor's employees, consultants, subcontractors or agents described in the Child Abuse Reporting Act, section 1116 et seq. of the Penal Code, and performing services under this Agreement shall report all known or suspected child abuse or neglect to a child protective agency as defined in Penal Code section 11165.9. This procedure shall include:

1. A requirement that all Contractor's employees, consultants, subcontractors or agents performing services shall sign a statement that they know of and will comply with the reporting requirements as defined in Penal Code section 11166(a).
2. Establishing procedures to ensure reporting even when employees, consultants, subcontractors, or agents who are not required to report child abuse under Penal Code section 11166(a), gain knowledge of or reasonably suspect that a child has been a victim of abuse or neglect.

II. Informing Materials for Persons Served

a. Basic Information Requirements. Contractor shall provide information in a manner and format that is easily understood and readily accessible to the persons served (42 C.F.R. § 438.10(c)(1)). Contractor shall provide all written materials for persons served in easily understood language, format, and alternative formats that take into consideration the special needs of individuals in compliance with 42 C.F.R. § 438.10(d)(6). Contractor shall inform the persons served that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

Contractor shall provide the required information in this section to each individual receiving Specialty Mental Health Services (SMHS) under this Agreement and upon request (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26., attachments 3, 4; Cal. Code Regs., tit. 9, §1810.360(e)).

Contractor shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all requirements regarding the same set forth in 42 C.F.R. § 438.10.

Contractor shall use the DHCS/County-developed beneficiary handbook and persons served notices (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).

b. **Electronic Submission.** Persons served information required in this section may only be provided electronically by the Contractor if all the following conditions are met:

i. The format is readily accessible;

ii. The information is placed in a location on the Contractor's website that is prominent and readily accessible;

iii. The information is provided in an electronic form which can be electronically retained and printed;

iv. The information is consistent with the content and language requirements of this Agreement;

v. The individual is informed that the information is available in paper form without charge upon request and the Contractor shall provide it upon request within five (5) business days (42 C.F.R. § 438.10(c)(6)).

c. **Language and Format.** Contractor shall provide all written materials, including taglines, for persons served or potential persons served in a font size no smaller than twelve (12) point (42 C.F.R. 438.10(d)(6)(ii)). Contractor shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the person served or potential person served at no cost.

Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Contractor's mental health education materials, available in the prevalent non-English languages in the County (42 C.F.R. § 438.10(d)(3)).

Contractor notify persons served, prospective persons served, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Inst. Code § 14727(a)(1); Cal. Code Regs. tit. 9 § 1810.410, subd. (e), para. (4)). Contractor shall make auxiliary aids and services available upon request and free of charge to each person served (42 C.F.R. § 438.10(d)(3)-(4)).

Contractor shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

d. **Beneficiary Informing Materials.** Each person served must receive and have access to the beneficiary informing materials upon request by the individual and when first receiving SMHS from Contractor. Beneficiary informing materials include but are not limited to:

i. Consumer Handbook
ii. Provider Directory
iii. Grievance form
iv. Appeal/Expedited Appeal form
v. Advance Directives brochure
vi. Change of Provider form
vii. Suggestions brochure
viii. Notice of Privacy Practices
ix. Notice of Adverse Benefit Determination (NOABDs – Including Denial and Termination notices)

x. Early & Periodic Screening, Diagnostic and Treatment (EPSDT) poster (if serving individuals under the age of 21)

xi. Contractor shall ensure beneficiary informing materials are displayed in the threshold languages of Fresno County at all service sites, including but not limited to the following:

1. Consumer Handbook
2. Provider Directory
3. Grievance form
4. Appeal/Expedited Appeal form
5. Advance Directives brochure
6. Change of Provider form
7. Suggestions brochure

All beneficiary informing written materials will use easily understood language and format (i.e. material written and formatted at a 6th grade reading level), and will use a font size no smaller than twelve (12) point. All beneficiary informing written materials shall inform beneficiaries of the availability of information in alternative formats and how to make a request for an alternative format. Inventory and maintenance of all beneficiary informing materials will be maintained by the County's DBH Plan Administration Division. Contractor will ensure that its written materials include taglines or that an additional taglines document is available.

e. **Beneficiary Handbook.** Contractor shall provide each person served with a beneficiary handbook at the time the individual first accesses services and thereafter upon request. The beneficiary handbook shall be provided to beneficiaries within fourteen (14) business days after receiving notice of enrollment. Contractor shall give each individual notice of any significant change to the information contained in the beneficiary handbook at least thirty (30) days before the intended effective date of change as per BHIN 22-060.

f. **Accessibility.** Required informing materials must be electronically available on Contractor's website and must be physically available at the Contractor's facility lobby for individuals' access.

Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or audio) and auxiliary aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to

persons served within five (5) business days. Large print materials shall be in a minimum of eighteen (18) point font size.

Informing materials will be considered provided to the individual if Contractor does one or more of the following:

i. Mails a printed copy of the information to the mailing address of the person served before the individual receives their first specialty mental health service;
ii. Mails a printed copy of the information upon the individual's request to their mailing address;
iii. Provides the information by email after obtaining the agreement of the person served to receive the information by email;
iv. Posts the information on the Contractor's website and advises the person served in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that individuals with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
v. Provides the information by any other method that can reasonably be expected to result in the person served receiving that information. If Contractor provides informing materials in person, when the individual first receives specialty mental health services, the date and method of delivery shall be documented in the file of the person served.

g. **Provider Directory**. Contractor must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.

Contractor must make available to persons served, in paper form upon request and electronic form, specified information about the County provider network as per 42 C.F.R. §438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than thirty (30) calendar days after information is received to update provider information. A paper provider directory must be updated at least monthly as set forth in 42 C.F.R. § 438.10(h)(3)(i).

Any changes to information published in the provider directory must be reported to the County within two (2) weeks of the change.

Contractor will only need to report changes/updates to the provider directory for licensed, waivered, or registered mental health providers.

III. **Assurances**

Certification of Non-exclusion or Suspension from Participation in a Federal Health Care Program.

a. In entering into this Agreement, Contractor certifies that it is not excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act. Failure to so certify will render all provisions of this Agreement null and void and may result in the immediate termination of this Agreement.
b. In entering into this Agreement, Contractor certifies, that the Contractor does not employ or subcontract with providers or have other relationships with providers excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. Contractor shall conduct initial and monthly exclusion and suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US Department of Health and Human Services (DHHS):
    i. www.oig.hhs.gov/exclusions - Office of Inspector General's List of Excluded Individuals/Entities (LEIE) Federal Exclusions
    ii. www.sam.gov/content/exclusions - General Service Administration (GSA) Exclusions Extract
    iii. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
    iv. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
    v. Any other database required by DHCS or US DHHS.
c. In entering into this Agreement, Contractor certifies, that Contractor does not employ staff or individual contractors/vendors that are on the Social Security Administration's Death Master File. Contractor shall check the database prior to employing staff or individual contractors/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.

d. Contractor is required to notify County immediately if Contractor becomes aware of any information that may indicate their (including employees/staff and individual contractors/vendors) potential placement on an exclusions list.
e. Contractor shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
f. Contractor must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's LEIE, the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.
g. If Contractor finds a provider that is excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). The Contractor shall not certify or pay any excluded provider with Medi-Cal funds, must treat any payments made to an excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

IV. Inspection and Audit Requirements

a. **Internal Auditing.** Contractor shall institute and conduct a Quality Assurance Process for all services provided hereunder.

Contractor shall provide County with notification and a summary of any internal audit exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Contractor's internal audit process. Contractor shall provide this notification and summary to County as requested by the County.

b. **Access to Records.** Contractor shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Contractor shall allow County, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General, the Controller General of the United States, and any other authorized Federal and State agencies to evaluate performance under this Agreement, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor pertaining to such services at any time and as otherwise required under this Agreement.

V. **Right to Monitor**

a. **Right to Monitor.** County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, records of persons served, other pertinent items as requested, and shall have absolute right to monitor the performance of Contractor in the delivery of services provided under this Agreement. Full cooperation shall be given by the Contractor in any auditing or monitoring conducted, according to this Agreement.

b. **Accessibility.** Contractor shall make all of its premises, physical facilities, equipment, books, records, documents, agreements, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Controller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least ten (10) years from the final date of the Agreement period or in the event the Contractor has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR §438.230(c)(3)(I)-(ii)).

The County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Contractor at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Contractor's place of business, premises, or physical facilities (42 CFR §438.230(c)(3)(iv))

c. **Cooperation**. Contractor shall cooperate with County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by County. Should County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, County may audit, monitor, and/or request information from

Contractor to ensure compliance with laws, regulations, and requirements, as applicable.

d. **Probationary Status.** County reserves the right to place Contractor on probationary status should Contractor fail to meet performance requirements; including, but not limited to violations such as failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Contractor may be subject to Probationary Status or termination if agreement monitoring and auditing corrective actions are not resolved within specified timeframes.

e. **Record Retention**. Contractor shall retain all records and documents originated or prepared pursuant to Contractor's performance under this Agreement, including grievance and appeal records, and the data, information and documentation specified in 42 CFR parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, records of persons served, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for persons served.

f. **Facilities and Assistance.** Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Contractor.

g. **County Discretion to Revoke.** County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Contractor has not performed satisfactorily.

h. **Site Inspection.** Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Contractor shall permit authorized County, state, and/or federal agency(ies), through any authorized representative,

the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. 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 of the Contractor.

VI. **Complaint Logs and Grievances**

a. **Documentation**. Contractor shall log complaints and the disposition of all complaints from a person served or their family. Contractor shall provide a copy of the detailed complaint log entries concerning County-sponsored persons served to County at monthly intervals by the tenth (10th) day of the following month, in a format that is mutually agreed upon. Contractor shall allow persons served or their representative to file a grievance either orally, or in writing at any time with the Behavioral Health Plan. In the event Contractor is notified by a person served or their representative of a discrimination grievance, Contractor shall report discrimination grievances to the County within twenty-four (24) hours. The Contractor shall not require a person served or their representative to file a Discrimination Grievance with the County before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

b. **Rights of Persons Served**. Contractor shall comply with applicable laws and regulations relating to patients' rights, including but not limited to Wel. & Inst. Code 5325, Cal. Code Regs., tit. 9, sections 862 through 868, and 42 CFR § 438.100. The Contractor shall ensure that its subcontractors comply with all applicable patients' rights laws and regulations.

c. **Incident Reporting.** Contractor shall file an incident report for all incidents involving persons served, following County DBH's Incident Reporting protocol.

VII. Compliance Requirements

a. **Internal Monitoring and Auditing**

i. Contractor shall be responsible for conducting internal monitoring and auditing of its agency. Internal monitoring and auditing include, but are not limited to billing practices, licensure/certification verification and adherence to County, State and Federal regulations.

1. Contractor shall not submit false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.
2. Contractor shall bill only for those eligible services actually rendered which are also fully documented.
3. Contractor shall ensure all employees/service providers maintain current licensure/certification/registration/waiver status as required by the respective licensing/certification Board, applicable governing State agency(ies) and Title 9 of the California Code of Regulations.

ii. Should Contractor identify improper procedures, actions or circumstances, including fraud/waste/abuse and/or systemic issue(s), Contractor shall take prompt steps to correct said problem(s). Contractor shall report to DBH any overpayments discovered as a result of such problems no later than five (5) business days from the date of discovery, with the appropriate documentation, and a thorough explanation of the reason for the overpayment. Prompt mitigation, corrective action and reporting shall be in accordance with the DBH Overpayment Policy and PPG Prevention, Detection, Correction of Fraud, Waste and Abuse which will be provided to Contractor at its request.

b. Compliance Program

i. The County DBH has established a Compliance Office for purposes of ensuring adherence to all standards, rules and regulations related to the provision of services and expenditure of funds in Federal and State health care programs. Contractor shall either adopt DBH's Compliance Plan/Program or establish its own Compliance Plan/Program and provide documentation to County DBH to evaluate whether the Program is consistent with the elements of a Compliance Program as recommended by the United States Department of Health and Human Services, Office of Inspector General.

ii. Contractor's Compliance Program must include the following elements:

1. Designation of a compliance officer who reports directly to the Chief Executive Officer and the Contactor's Board of Directors and compliance committee comprised of senior management who are charged with overseeing the Contractor's compliance program and

compliance with the requirements of this account. The committee shall be accountable to the Contractor's Board of Directors.

iii. Policies and Procedures

1. Contractor shall have written policies and procedures that articulate the Contractor's commitment to comply with all applicable Federal and State standards. Contractor shall adhere to applicable County DBH Policies and Procedures relating to the Compliance Program or develop its own compliance-related policies and procedures.

iv. Contractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they arise, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

v. Contractor shall implement and maintain written policies for all County DBH-funded employees, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including information about rights of employees to be protected as whistleblowers.

vi. Contractor shall maintain documentation, verification or acknowledgement that the Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors are aware of these Policies and Procedures and the Contractor’s Compliance Program.

vii. Contractor shall have a Compliance Plan demonstrating the seven (7) elements of a Compliance Plan. Contractor has the option to develop its own or adopt County DBH's Compliance Plan. Should Contractor develop its own Plan, Contractor shall submit the Plan prior to implementation for review and approval to:

Fresno County DBH Compliance Office
1925 E. Dakota Ave. Ste A

Fresno, California 93726

Or send via email to: DBHCompliance@fresnocountyca.gov

c. Program Integrity Requirements

i. As a condition for receiving payment under a Medi-Cal managed care program, Contractor shall comply with the provisions of Title 42 CFR Sections 438.604, 438.606, 438.608 and 438.610. Contractor must have administrative and management processes or procedures, including a mandatory compliance plan, that are designed to detect and prevent fraud, waste or abuse.

ii. If Contractor identifies an issue or receives notification of a complaint concerning an incident of possible fraud, waste, or abuse, Contractor shall immediately notify County DBH; conduct an internal investigation to determine the validity of the issue/complaint; and develop and implement corrective action if needed.

iii. If Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue if egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall immediately report to the County DBH Compliance Office for investigation, review and/or disposition.

iv. Contractor shall fully cooperate with all audits, reviews, or investigations conducted by the DBH Compliance Office. Never conceal, falsify, or alter records, provide false information, or otherwise obstruct any audit or investigation.

v. Contractor shall immediately report to DBH any overpayments identified or recovered, specifying the overpayments due to potential fraud.

vi. Contractor shall immediately report any information about changes in the circumstances of the person served that may affect the person's eligibility, including changes in the residence of the person served or the death of the individual.

vii. Contractor shall immediately report any information about a change in Contractor's or Contractor's staff circumstances that may affect eligibility to participate in the behavioral health program.

viii. Contractor understands DBH, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Contractor at any time if there is a reasonable possibility of fraud or similar risk.

d. Code of Conduct

i. Contractor shall take precautions to ensure that claims are prepared and submitted accurately, timely and are consistent with all applicable laws, regulations, rules or guidelines.

ii. Contractor shall ensure that no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind are submitted.

iii. Contractor shall bill only for eligible services actually rendered and fully documented.

iv. Contractor shall act promptly to investigate and correct problems if errors in claims or billing are discovered.

v. Contractor shall comply with County's Code of Conduct and Ethics and the County's Compliance Program in accordance with Exhibit B – Attachment H to this Agreement, titled "Fresno County Behavioral Health Plan Compliance Program Code of Conduct".

e. **Network Adequacy.** Contractor shall ensure that all services covered under this Agreement are available and accessible to persons served in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206(a), (c)).

Contractor shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to the County, utilizing a provided template or other designated format.

Contractor shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services.

To the extent possible and appropriately consistent with CCR, Title 9, §1830.225 and 42 C.F.R. §438.3 (l), the Contractor shall provide a person served the ability to choose the person providing services to them.

VIII. <u>Federal and State Laws.</u>

a. **Health Insurance Portability and Accountability Act.** County and Contractor each consider and represent themselves as covered entities as defined by the U.S. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191(HIPAA) and

agree to use and disclose Protected Health Information (PHI) as required by law.

County and Contractor acknowledge that the exchange of PHI between them is only for treatment, payment, and health care operations.

County and Contractor intend to protect the privacy and provide for the security of PHI pursuant to this Agreement in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (HITECH), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (HIPAA Regulations) and other applicable laws.

As part of the HIPAA Regulations, the Privacy Rule and the Security Rule require Contractor to enter into an agreement containing specific requirements prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations.

b. Contractor and County mutually agree to maintain the confidentiality of records and information of persons served in compliance with all applicable State and Federal statutes and regulations, including, but not limited to, HIPAA, California Confidentiality of Medical Information Act (CMIA), and California Welfare and Institutions Code section 5328. The Parties shall inform all of their employees and agents who perform services under this Agreement of the confidentiality provisions of all applicable statutes.

c. The County is a “Covered Entity,” and the Contractor is a “Business Associate,” as these terms are defined by 45 CFR 160.103. As a Business Associate, Contractor agrees to comply with the terms of Exhibit B – Attachment I to this Agreement, titled “Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement”.

IX. Quality Management Requirements.

a. **Reporting.**

   i. Outcomes Reports. Contractor shall complete Outcomes Reports in the format set by County. Outcomes reports shall be submitted to County’s DBH for review within thirty (30) days of the end of each quarter.

b. **Quality Improvement Activities and Participation.** Contractor shall comply with the County’s ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 CFR. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.

Contractor shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to State and Federal requirements and responsibilities, to improve health outcomes and individuals' satisfaction with services over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, individual and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and recredentialing, and person served grievances. Contractor shall measure, monitor, and annually report to the County on its performance.

X. Cultural and Linguistic Competency

a. **General.** All services, policies and procedures shall be culturally and linguistically appropriate. Contractor shall participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all Culturally and Linguistically Appropriate Service (CLAS) standards and requirements as set forth in Exhibit B – Attachment J to this Agreement, titled "National Standards for Culturally and Linguistically Appropriate Services". Contractor shall participate in the County's efforts to promote the delivery of services in a culturally responsive and equitable manner to all individuals, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity including active participation in the County's Diversity, Equity and Inclusion Committee.

b. **Policies and Procedures.** Contractor shall comply with requirements of policies and procedures for ensuring access and appropriate use of trained interpreters and material translation services for all limited and/or no English proficient persons served, including, but not limited to, assessing the cultural and linguistic needs of the person served, training of staff on the policies and procedures, and monitoring its language assistance program. Contractor's policies and procedures shall ensure compliance of any subcontracted providers with these requirements.

c. **Interpreter Services.** Contractor shall notify its persons served that oral interpretation is available for any language and written translation is available in prevalent languages and that auxiliary aids and services are available upon request, at no cost and in a timely manner for limited and/or no English proficient

persons served and/or persons served with disabilities. Contractor shall avoid relying on an adult or minor child accompanying the person served to interpret or facilitate communication; however, if the person refuses language assistance services, the Contractor must document the offer, refusal, and justification in the file of the person served.

d. **Interpreter Qualifications.** Contractor shall ensure that employees, agents, subcontractors, and/or partners who interpret or translate for a person served or who directly communicate with a person in a language other than English (1) have completed annual training provided by County at no cost to Contractor; (2) have demonstrated proficiency in the language of the person served; (3) can effectively communicate any specialized terms and concepts specific to Contractor's services; and (4) adheres to generally accepted interpreter ethic principles. As requested by County, Contractor shall identify all who interpret for or provide direct communication to any program person served in a language other than English and identify when the Contractor last monitored the interpreter for language competence.

e. **CLAS Standards.** Contractor shall submit to County for approval, within ninety (90) days from date of contract execution, Contractor's plan to address all fifteen (15) National Standards for Culturally and Linguistically Appropriate Service (CLAS), as published by the Office of Minority Health and as set forth in Exhibit B – Attachment J, "National Standards for Culturally and Linguistically Appropriate Services". As the CLAS standards are updated, Contractor's plan must be updated accordingly. As requested by County, Contractor shall be responsible for conducting an annual CLAS self-assessment and providing the results of the self-assessment to the County. The annual CLAS self-assessment instruments shall be reviewed by the County and revised as necessary to meet the approval of the County.

f. **Training Requirements.** Cultural responsiveness training for Contractor staff should be substantively integrated into health professions education and training at all levels, both academically and functionally, including core curriculum, professional licensure, and continuing professional development programs. As requested by County, Contractor shall report on the completion of cultural responsiveness trainings to ensure direct service providers are completing annual cultural responsiveness training.

g. **Continuing Cultural Responsiveness.** Contractor shall create and sustain a forum that includes staff at all agency levels to discuss cultural responsiveness. Contractor shall designate a representative from Contractor's team to attend County's Diversity, Equity and Inclusion Committee.

Fresno County Department of Behavioral Health
Guiding Principles of Care Delivery

DBH VISION:

Health and well-being for our community.

DBH MISSION:

DBH, in partnership with our diverse community, is dedicated to providing quality, culturally responsive, behavioral health services to promote wellness, recovery, and resiliency for individuals and families in our community.

DBH GOALS:

Quadruple Aim

- Deliver quality care
- Maximize resources while focusing on efficiency
- Provide an excellent care experience
- Promote workforce well-being

GUIDING PRINCIPLES OF CARE DELIVERY:

The DBH 11 principles of care delivery define and guide a system that strives for excellence in the provision of behavioral health services where the values of wellness, resiliency, and recovery are central to the development of programs, services, and workforce. The principles provide the clinical framework that influences decision-making on all aspects of care delivery including program design and implementation, service delivery, training of the workforce, allocation of resources, and measurement of outcomes.

1. Principle One - Timely Access & Integrated Services

    - Individuals and families are connected with services in a manner that is streamlined, effective, and seamless
    - Collaborative care coordination occurs across agencies, plans for care are integrated, and whole person care considers all life domains such as health, education, employment, housing, and spirituality
    - Barriers to access and treatment are identified and addressed
    - Excellent customer service ensures individuals and families are transitioned from one point of care to another without disruption of care

Fresno County Department of Behavioral Health
Guiding Principles of Care Delivery

2. Principle Two - Strengths-based

    - Positive change occurs within the context of genuine trusting relationships
    - Individuals, families, and communities are resourceful and resilient in the way they solve problems
    - Hope and optimism is created through identification of, and focus on, the unique abilities of individuals and families

3. Principle Three - Person-driven and Family-driven

    - Self-determination and self-direction are the foundations for recovery
    - Individuals and families optimize their autonomy and independence by leading the process, including the identification of strengths, needs, and preferences
    - Providers contribute clinical expertise, provide options, and support individuals and families in informed decision making, developing goals and objectives, and identifying pathways to recovery
    - Individuals and families partner with their provider in determining the services and supports that would be most effective and helpful and they exercise choice in the services and supports they receive

4. Principle Four - Inclusive of Natural Supports

    - The person served identifies and defines family and other natural supports to be included in care
    - Individuals and families speak for themselves
    - Natural support systems are vital to successful recovery and the maintaining of ongoing wellness; these supports include personal associations and relationships typically developed in the community that enhance a person's quality of life
    - Providers assist individuals and families in developing and utilizing natural supports.

5. Principle Five - Clinical Significance and Evidence Based Practices (EBP)

    - Services are effective, resulting in a noticeable change in daily life that is measurable.
    - Clinical practice is informed by best available research evidence, best clinical expertise, and values and preferences of those we serve

Fresno County Department of Behavioral Health
Guiding Principles of Care Delivery

- Other clinically significant interventions such as innovative, promising, and emerging practices are embraced

6. Principle Six - Culturally Responsive

   - Values, traditions, and beliefs specific to an individual's or family's culture(s) are valued and referenced in the path of wellness, resilience, and recovery
   - Services are culturally grounded, congruent, and personalized to reflect the unique cultural experience of each individual and family
   - Providers exhibit the highest level of cultural humility and sensitivity to the self-identified culture(s) of the person or family served in striving to achieve the greatest competency in care delivery

7. Principle Seven - Trauma-informed and Trauma-responsive

   - The widespread impacts of all types of trauma are recognized and the various potential paths for recovery from trauma are understood
   - Signs and symptoms of trauma in individuals, families, staff, and others are recognized and persons receive trauma-informed responses
   - Physical, psychological and emotional safety for individuals, families, and providers is emphasized

8. Principle Eight - Co-occurring Capable

   - Services are reflective of whole-person care; providers understand the influence of bio-psycho-social factors and the interactions between physical health, mental health, and substance use disorders
   - Treatment of substance use disorders and mental health disorders are integrated; a provider or team may deliver treatment for mental health and substance use disorders at the same time

9. Principle Nine - Stages of Change, Motivation, and Harm Reduction

   - Interventions are motivation-based and adapted to the person's stage of change
   - Progression though stages of change are supported through positive working relationships and alliances that are motivating

Fresno County Department of Behavioral Health
Guiding Principles of Care Delivery

- Providers support individuals and families to develop strategies aimed at reducing negative outcomes of substance misuse though a harm reduction approach
- Each individual defines their own recovery and recovers at their own pace when provided with sufficient time and support

10. Principle Ten - Continuous Quality Improvement and Outcomes-Driven

- Individual and program outcomes are collected and evaluated for quality and efficacy
- Strategies are implemented to achieve a system of continuous quality improvement and improved performance outcomes
- Providers participate in ongoing professional development activities needed for proficiency in practice and implementation of treatment models

11. Principle Eleven - Health and Wellness Promotion, Illness and Harm Prevention, and Stigma Reduction

- The rights of all people are respected
- Behavioral health is recognized as integral to individual and community well-being
- Promotion of health and wellness is interwoven throughout all aspects of DBH services
- Specific strategies to prevent illness and harm are implemented at the individual, family, program, and community levels
- Stigma is actively reduced by promoting awareness, accountability, and positive change in attitudes, beliefs, practices, and policies within all systems
- The vision of health and well-being for our community is continually addressed through collaborations between providers, individuals, families, and community members

FRESNO COUNTY BEHAVIORAL HEALTH PLAN
RIGHTS OF PERSONS SERVED

I. Grievances

Fresno County Behavioral Health Plan (BHP) provides beneficiaries with a grievance and appeal process and an expedited appeal process to resolve grievances and disputes at the earliest and the lowest possible level.

Title 9 of the California Code of Regulations requires that the BHP and its fee-for-service providers give verbal and written information to Medi-Cal beneficiaries regarding the following:

- How to access specialty mental health services
- How to file a grievance about services
- How to file for a State Fair Hearing

The BHP has developed a Consumer Guide, a beneficiary rights poster, a grievance form, an appeal form, and Request for Change of Provider Form. All of these beneficiary materials must be posted in prominent locations where Medi-Cal beneficiaries receive outpatient specialty mental health services, including the waiting rooms of providers' offices of service.

Please note that all fee-for-service providers and contract agencies are required to give the individuals served copies of all current beneficiary information annually at the time their treatment plans are updated and at intake.

Beneficiaries have the right to use the grievance and/or appeal process without any penalty, change in mental health services, or any form of retaliation. All Medi-Cal beneficiaries can file an appeal or state hearing.

Grievances and appeals forms and self-addressed envelopes must be available for beneficiaries to pick up at all provider sites without having to make a verbal or written request. Forms can be sent to the following address:

Fresno County Behavioral Health Plan
P.O. Box 45003
Fresno, CA 93718-9886
(800) 654-3937 (for more information)
(559) 488-3055 (TTY)

II. Provider Problem Resolution and Appeals Process

The BHP uses a simple, informal procedure in identifying and resolving provider concerns and problems regarding payment authorization issues, other complaints and concerns.

a. **Informal provider problem resolution process** – the provider may first speak to a Fresno County Department of Behavioral Health (DBH) team member regarding his or her complaint or concern.

The DBH Team Member will attempt to settle the complaint or concern with the provider. If the attempt is unsuccessful and the provider chooses to forego the informal grievance process, the provider will be advised to file a written complaint to the BHP address (listed above).

b. **Formal provider appeal process** – the provider has the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun, when the complaint concerns a denied or modified request for BHP payment authorization, or the process or payment of a provider's claim to the BHP.

c. **Payment authorization issues** – the provider may appeal a denied or modified request for payment authorization or a dispute with the BHP regarding the processing or payment of a provider's claim to the BHP. The written appeal must be submitted to the BHP within ninety (90) calendar days of the date of the receipt of the non-approval of payment.

The BHP shall have sixty (60) calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

If the appeal concerns a denial or modification of payment authorization request, the BHP utilizes a DBH Team Member who was not involved in the initial denial or modification decision to determine the appeal decision.

If the DBH Team Member reverses the appealed decision, the provider will be asked to submit a revised request for payment within thirty (30) calendar days of receipt of the decision.

d. **Other complaints** – if there are other issues or complaints, which are not related to payment authorization issues, providers are encouraged to send a letter of complaint to the BHP. The provider will receive a written response from the BHP within sixty (60) calendar days of receipt of the complaint. The decision rendered by the BHP is final.

DOCUMENTATION STANDARDS FOR PERSON SERVED RECORDS

The documentation standards are described below under key topics related to care for persons served. All standards must be addressed in the record of each person served; however, there is no requirement that the record have a specific document or section addressing these topics. All medical records shall be maintained for a minimum of 10 years from the date of the end of the Agreement.

I. Assessments

a. The following areas will be included as a part of a comprehensive record for each person served:
   i. Presenting problems, including impairments in function, and current mental status exam.
   ii. Traumatic incidents which include trauma exposures, trauma reactions, trauma screenings, and systems involvement if relevant
   iii. Behavioral health history including mental health history, substance use/abuse, and previous services
   iv. Medical history including physical health conditions, medications, and developmental history
   v. Psychosocial factors including family, social and life circumstances, cultural considerations
   vi. Strengths, risks, and protective factors, including safety planning
   vii. Clinical summary, treatment recommendations, and level of care determination including diagnostic and clinical impression with a diagnosis
   viii. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.

b. Timeliness/Frequency Standard for Assessment
   i. The time period to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion.
   ii. Assessments shall be completed within a reasonable time and in accordance with generally accepted standards of practice.

II. Problem list

a. The use of a Problem List has largely replaced the use of treatment plans and is therefore required to be part of the record for each person served. The problem list

shall be updated on an ongoing basis to reflect the current presentation of the person in care.

b. The problem list shall include, but is not limited to, the following:
    i. Diagnoses identified by a provider acting within their scope of practice
    ii. Problems identified by a provider acting within their scope of practice
    iii. Problems or illnesses identified by the person in care and/or significant support person if any
    iv. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed

III. Treatment and Care Plan Requirements

a. Targeted Case Management
    i. Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational, and other services needed by the person in care
    ii. Identifies a course of action to respond to the assessed needs of the person in care
    iii. Includes development of a transition plan when the person in care has achieved the goals of the care plan
    iv. Peer support services must be based on an approved care plan
    v. Must be provided in a narrative format in the person's progress notes
    vi. Updated at least annually
b. Services requiring Treatment Plans
    i. Therapeutic Behavioral Services (TBS)
    ii. Must have specific observable and/or specific quantifiable goals
    iii. Must identify the proposed type(s) of intervention
    iv. Must be signed (or electronic equivalent) by:
        1. the person providing the service(s), or
        2. a person representing a team or program providing services, or
        3. a person representing the MHP providing services when the plan for a person served is used to establish that the services are provided under the direction of an approved category of staff, and if the below staff are not the approved category,
        4. a physician

5. a licensed/ “waivered” psychologist
6. a licensed/ “associate” social worker
7. a licensed/ registered/marriage and family therapist or
8. a registered nurse

v. In addition:

1. Plans for each person served will be consistent with the diagnosis, and the focus of intervention will be consistent with the plan goals for the person served, and there will be documentation that the person served participated in and agreed with the plan. Examples of the documentation include, but are not limited to, reference to the participation by the person served and agreement by the person served in the body of the plan, the signature of the person served on the plan, or a description of the participation by the person served and agreement by the person served in progress notes.
2. The signature on the plan by the person served will be used as the means by which the Contractor documents the participation of the person served. When the signature of the person served is required on the plan for the person served and the person served refuses or is unavailable for signature, the plan for the person served plan will include a written explanation of the refusal or unavailability.
3. The Contractor will give a copy of the plan for the person served to the person served on request.

IV. Progress Notes

a. Providers shall create progress notes for the provision of all SMHS. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description. Progress notes shall include:

i. The type of service rendered.
ii. A narrative describing the service, including how the service addressed the beneficiary’s behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
iii. The date that the service was provided to the beneficiary.
iv. Duration of the service, including travel and documentation time.
v. Location of the beneficiary at the time of receiving the service.

vi. A typed or legibly printed name, signature of the service provider and date of signature.
vii. ICD 10 code
viii. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
ix. Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

b. Timeliness/Frequency of Progress Notes
   i. Progress notes shall be completed within 3 business days of providing a service, except for notes for crisis services, which shall be completed within 24 hours.
   ii. A note must be completed for every service contact

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH CONTRACTOR TRAINING REQUIREMENTS REFERENCE GUIDE

MENTAL HEALTH SERVICES

This Training Requirements Reference Guide identifies the required trainings that Contractor is responsible for offering to all employees, volunteers, interns, and student trainees of Contractor or its subcontractors who, in each case, are expected to perform professional services while contracted by County. There are some trainings offered by the County at no cost to Contractor, and those are identified within this document. The remaining trainings are the responsibility of Contractor to provide and cover associated costs. The expectations for Contractor staff attending County-offered trainings are included within this guide, with the understanding additional trainings may be required that are not listed; in such cases, Contractor will be informed. Contractor must consider and include sufficient time and funds for required trainings.

I. Trainings Provided by the Department of Behavioral Health (DBH)

a. **DBH New Hire General Compliance Training**

Duration: 40 Minutes

Contractor shall have their employees, subcontractors, volunteers, interns, and student trainees who, in each case, are expected to provide services under this Agreement with County, complete the New Hire Compliance Training within thirty (30) business days of hire or effective date of this Agreement, per Compliance Exhibit B, Attachment H. If contract effective date is for a renewed agreement, existing staff will not need to retake the training if the staff member has already completed the training within the same calendar year as the effective date of the renewed agreement.

New Hire General Compliance is self-paced and can be completed either through Relias Learning Management System (LMS) or on the DBH website. Additional information on how to complete the training can be found on the following webpage: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Care-Services/Behavioral-Health-Compliance/New-Hire-General-Compliance-Training

Contractor shall require its County-funded employees and subcontractors to complete this compliance training. After completion of this training, participants must sign the Contractor Acknowledgment and Agreement form and return this form to the DBH Compliance officer or designee. For additional questions about the training,

please contact your contract analyst or the DBH Compliance team at: DBHCompliance@fresnocountyca.gov.

i. **DBH Annual General Compliance Refresher Training**

Duration: 30 Minutes

General Compliance Refresher Training is an annual requirement for all employees, contractors, volunteers, interns, and student trainees working in behavioral health programs who are in their second or more years of service. This training is a modified version of the self-paced General Compliance Training and Contractor shall be assigned this training in Quarter 4 of each calendar year. An announcement from the DBH Compliance Program, DBH Staff Development, or your contract analyst regarding this training will be made prior to the assignment of this training. Contractor will have the option to complete the training either through the Relias Learning Management System (LMS) or through the DBH website. Contractors are given approximately a sixty (60) day window to complete this training from the training announcement date.

b. **Mental Health Documentation & Billing Training**

Duration: 1 Hour 30 Minutes

All contracted provider organization employees, subcontractors, volunteers, interns, and students providing services are to complete Documentation & Billing Training within thirty (30) business days of hire or contract effective date. If contract effective date is a renewal, existing staff will not need to retake the training if they have already completed it with their agency. Contractor shall be required to complete this training as a prerequisite for providing direct services, processing billing, conducting quality assurance services, clinical supervision, or other similar services under this agreement. Contractor is expected to contact their assigned contract analysts if they are unsure about training requirements for any specific classifications.

Documentation & Billing is a training provided at least one time per month. Registration is completed via Eventbrite for each session; links to register can be found on the webpage below:

https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/Contract-Provider-Resources/New-Hire-ComplianceDoc-Billing-Training

The expectation is that Contractor will register their County-funded employees at least one week in advance of the training date. For any registration issues or other

questions about the training, they can contact DBHStaffDevelopment@fresnocountyca.gov.

c. **Invoicing Training**

Contractor shall be responsible for collection and managing data in a manner to be determined by the California Department of Health Care Services (DHCS) and Behavioral Health Plan in accordance with applicable rules and regulations. DBH's Electronic Health Record (EHR) is a critical source of information for purposes of monitoring service volume and obtaining reimbursement. Contractor's staff responsible for checking Medi-Cal eligibility shall attend DBH's training on equipment reporting for assets, intangible and sensitive minor assets, DBH's EHR system and related cost reporting.

d. **Notice of Adverse Benefit Determination (NOABD) Training**

Duration: 8 Minutes

A Notice of Adverse Benefit Determination (NOABD) is a formal mechanism for notifying a person served of an adverse benefit determination in writing (e.g., denial or limited authorization of a requested service, denial of payment for a service, or failure to provide services in a timely manner).

This training outlines usage practices, timelines, and examples for each type of NOABD. Contractor can find the training in the Announcements section on the following webpage: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/Contract-Provider-Resources/Notifications-Associated-Documents.

Contractor shall be responsible for DBH-funded providers completing this training within sixty (60) days of hire or contract effective date.

e. **SmartCare Full Electronic Health Record New User Mental Health Training***

Duration: 3.5 - 4 Hours

This is a basic training for new users who are direct clinical service providers employed by Contractors that will be using SmartCare as their full EHR. Participants will have the opportunity to apply CalMHSA's SmartCare training materials and review relevant SmartCare workflows, clinical documents, and forms.

Training dates and reference material can be found on the following link: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/SmartCare

*This training is available to Contractor at no cost and highly recommended. Although this training is not required, Contractor is responsible for understanding and utilizing SmartCare as indicated once contracted with County DBH.

f. **SmartCare Electronic Health Record New User Front Desk Training***

Duration: 4 Hours

This is a basic training for new users who are employed by Contractors who will be using SmartCare as their full EHR. Participants will have the opportunity to review how to navigate SmartCare, perform coverage information set up, error corrections, set up Appointments, and basic troubleshooting of common issues.

Training dates and reference material can be found on the following link: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/SmartCare

*This training is available to Contractor at no cost and highly recommended. Although this training is not required, Contractor is responsible for understanding and utilizing SmartCare as indicated once contracted with County DBH.

g. **SmartCare Lite Electronic Health Record Mental Health Training* (Provider Entry Only Training)**

Duration: Varies

This training is for select Contractors that do not intend to fully use County DBH's SmartCare EHR system but rather only some functions, otherwise referred to as a "SmartCare Lite User". This training is intended to supplement and reinforce the CalMHSA SmartCare trainings, user guide, and workflow information for SmartCare Lite Users. This supplemental training/technical support is offered by the DBH Planning and Quality Management Division's Quality Improvement Team upon request.

Required prerequisite material can be found on the following link: https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/SmartCare

*This training is available to Contractor at no cost and highly recommended. Although this training is not required, Contractor is responsible for understanding and utilizing SmartCare as indicated once contracted with County DBH.

h. **Wellness, Hope and Recovery Training**

Duration: 3 Hours and 30 Minutes

This training is designed for direct mental health providers. It aims to enhance their understanding of wellness and recovery concepts, highlight the importance of hope in the healing process, and offer strategies for instilling hope in others. Additionally, the training will address providers' own personal wellness to support sustainable, compassionate care.

* This training is available to selected bidder at no cost and highly recommended. Contractor is responsible for understanding and incorporating these concepts in clinical practice as indicated once contracted with County DBH.

II. Trainings for Specialty Mental Health Providers by Specialization

a. **Mobile Crisis Services Trainings**

Duration: 21 Hours

Any contracted provider providing mobile crisis services shall complete the state-required training series. For example, the current training series is provided by the Medi-Cal Mobile Crisis Training and Technical Assistance Center (M-TAC). This ten-part training series is available on the DBH Relias learning management system. For assistance with assigning the trainings, please contact DBHRelias@Fresnocountyca.gov.

b. **California Integrated Practice Child & Adolescent Needs & Strengths (CA IP CANS)**

Duration: 8 Hours

The CA IP CANS is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth, ages zero (0) up to age twenty-one (21), and family information to inform planning, support decisions, and monitor outcomes.

Contracted providers are required to complete the CANS assessment for all persons served ages zero (0) up to age twenty-one (21) at the beginning of treatment, updated every six (6) months following the first administration, and at the end of treatment. DBH provides access for a virtual, self-paced training and certification testing for use of the tool. For any questions about the training or assistance with registration, please contact DBHStaffDevelopment@fresnocountyca.gov.

III. Contractor is Responsible for Ensuring and/or Providing These Trainings are Offered and Completed

a. **Cultural Responsiveness Trainings**

Contractor shall have DBH-funded providers complete annual trainings on cultural competency, awareness, and diversity as identified by Contractor, and/or via the County's eLearning system. Contractor's DBH-funded providers shall be appropriately trained in providing services in a culturally sensitive manner and shall attend civil rights training as identified by Contractor, or online via the County's eLearning system.

Information on annual cultural responsiveness training requirements will be provided by the DBH Division Manager serving as Ethnic Services Manager and Diversity Services Coordinator. Both parties are working locally and at the state level to address the need for thorough training to improve culturally responsive care and to meet the National Culturally and Linguistically Appropriate Services standards, while also understanding the impact that the training hours can have on productivity in fee-for-service programs.

For additional information, Contractors should contact their assigned contract analyst.

DBH is available to assist Contractor's efforts toward cultural and linguistic responsiveness by providing the following:

i. Technical assistance regarding culturally responsive training requirements.
ii. Mandatory cultural responsiveness training for Contractor's DBH-funded staff if training capacity allows.
iii. Technical assistance for translating information into County's threshold languages (currently Spanish and Hmong and subject to change). Contractors are responsible for securing translation services and all associated costs.

b. **Health Insurance Portability and Accountability Act (HIPAA) Training**

As a covered entity, or a business associate of a covered entity, providers shall meet the training requirements described in the HIPAA Privacy Rule 45 CFR § 164.530(b)(1) and the HIPAA Security Rule 45 CFR § 164.308(a)(5). Providers may use their discretion to select an appropriate HIPAA training. Training shall be completed by all DBH-funded staff within thirty (30) days of contract execution or hire and annually thereafter.

c. **Medi-Cal Eligibility Verification Training**
Contractor shall ensure their direct program staff receive training from DBH regarding person-served eligibility for Medi-Cal. The County will require the Contractor to verify the third-party payer of the person served (i.e., Medi-Cal) eligibility prior to starting services and every month thereafter, per the Provider Manual. Claims may be rejected for services rendered to persons ineligible for Medi-Cal, unless prior payment arrangements have been made.

d. **CalMHSA Clinical Practice Training**
Duration: 8 hours
Any contracted clinical provider is required to complete the CalMHSA Clinical Practice Training Modules in CalMHSA's web-based training system called Moodle. Clinical providers are expected to complete training within sixty (60) days of beginning employment.
CalMHSA's web-based training system, https://moodle.calmhsalearns.org.

e. **Language Assistance Program Training**
Contractor shall be responsible for implementing policies and procedures and training staff to ensure access and appropriate use of trained interpreters and material translation services for all Limited English Proficient (LEP) persons served. This includes, but is not limited to, assessing the cultural and linguistic needs of its persons served. The Contractor's procedures shall include ensuring compliance of any sub-contracted providers with these requirements.

IV. Training Expectations for County-Provided Trainings

a. Attendees are to adhere to wearing business casual attire, broadly defined as a code of dress that blends traditional business wear with a more relaxed style that is still professional and appropriate for an office environment, unless specifically directed otherwise or instructed by Trainers. Attendees are expected to dress in respectful, culturally inclusive attire.
b. Interested attendees shall register at least one week in advance of the training date.
c. Attendees shall be expected to be ready and prepared to be engaged by the training start time. Attendees are also expected to arrive back on time from breaks, including lunch, and attend the training through completion.
d. Attendees who arrive fifteen (15) minutes late, or more, shall be requested to return to their work site and their organization will be notified. Similarly, attendees may not

leave a training prior to the scheduled end time. Those who miss fifteen (15) minutes or more of training in total throughout the day may be asked to re-enroll for a later training date if one is available.

e. Personal use of cell phones, laptops and tablets, except for in cases of emergency, should not be used during training and should be set to silent. Any calls shall be taken outside of the training space. Attendees shall inform trainers and/or Staff Development if they are expecting to be contacted for any reason; this shall be done before the training begins, if possible. Other cell phone use, such as texting, playing games or browsing the internet shall not be permitted while training is in session. If conduct is deemed disruptive to colleagues and/or trainer(s), attendees shall be asked to leave the training and return to their work site. Organizations will be notified.

f. At times, attendees shall be required to complete pre- and post-training class assignments, as part of the learning objectives. Attendees shall be required to complete assigned activities to receive Continuing Education Credits, certification, and training credit, if applicable.

g. Attendees shall be expected to complete pre- and/or post-training evaluations, when available.

h. Attendees shall notify Staff Development with their supervisor copied at (559) 600-9680 or DBHStaffDevelopment@fresnocountyca.gov at the earliest possible date if they can no longer attend a training for which they have registered.

V. Use of DBH Training Facilities

a. **Parking**

Attendees shall park in undesignated stalls at DBH training sites. Any parking restrictions shall be communicated prior to the training date or prior to the training start time.

b. **Use of Facilities**

Attendees shall be respectful while occupying the training space, keeping it and the surrounding area neat and clean. Attendees are encouraged to bring a reusable water bottle but shall be cognizant of and clean any spills. If the training allows for food, attendees shall ensure that their area is clean and dispose of any waste prior to leaving the training space.

MENTAL HEALTH PROGRAM OUTCOMES AND PERFORMANCE MEASUREMENTS

I. Behavioral Health Transformation Goals

Following the passage of Proposition 1 and the implementation of the Behavioral Health Services Act (BHSA), the Department of Health Care Services (DHCS) established fourteen (14) Behavioral Health Goals as a key requirement of Behavioral Health Transformation (BHT). Counties were provided with six (6) priority measures, as well as the requirement to choose one of eight (8) additional measures. These measures are the following:

Priority Measures

- Reducing Homelessness
- Reducing Institutionalization
- Reduce Justice-Involvement
- Reduce Child Removals
- Reduce Untreated Behavioral Health Conditions
- Increasing Access to Care

Additional Measures

- Reduce Suicides
- Reduce Overdoses
- Increase Care Experience
- Increase Quality of Life
- Increase Social Connection
- Increase Engagement in Work **(DBH SELECTED)**
- Increase Engagement in School
- Prevention and Treatment of Co-Occurring Physical Health Conditions

In accordance with those requirements, the Contractor shall align services with one, or more, of the BHT Behavioral Health Goal(s) as determined by DBH. The Contractor shall be evaluated according to the performance measures associated with the individual BHT goals determined by DBH to be relevant to the level of care being provided.

All BHT goals and performance measures are contingent upon DHCS policy and guidelines and may be subject to change.

DHCS shall establish specific measures and data sets to be used for assessing the progress and or attainment each BHT goal.

II. Behavioral Health Accountability Set

In alignment with the DHCS Behavioral Health Quality & Equity Policy, DBH shall review performance in applicable measures from the Behavioral Health Accountability Set, when available. Contractor shall be required to align services with these measures to ensure a high level of performance. These measures include:

- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Hospitalization for Mental Illness
- Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications[1]

BHSA alignment is contingent upon DHCS policy and guidelines and may be subject to change; Contractor will be expected to continue to align services with any future added measures during the life of the service contract.

III. Network Adequacy

Contractor will be expected to comply with all applicable Network Adequacy requirements established by DHCS. Among these requirements is the Timely Access Data Tool (TADT). DBH shall review Contractor performance in accordance with the DHCS requirements. These timeliness requirements include:

Service Type	Standard*
Outpatient Non-Urgent Non-Psychiatric SMHS	Offered an appointment within 10 business days of request for services.
Psychiatric Services	Offered an appointment within 15 business days of request for services.
All Urgent SMHS Appointments	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[30]
*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H). ** Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[31]	

IV. Other Mandated Performance Measures

DBH will monitor the Contractor for other performance measures that are mandated by DHCS or evaluate essential processes. Measures may include, but are not limited to:

- Timeliness to first offered/kept service
- Enhanced Care Management and Community Support referrals
- Service volume
- Discharge reason
- Length of stay
- Consumer Perception Survey completion
- Hospital and Emergency Department follow-up timeliness
- Successful transition to lower/higher level of care
- Other mandated and essential measures

STATE BEHAVIORAL HEALTH REQUIREMENTS

I. CONTROL REQUIREMENTS

The County and its subcontractors shall provide services in accordance with all applicable Federal and State statutes and regulations.

II. PROFESSIONAL LICENSURE

All (professional level) persons employed by the County Mental Health Plan (directly or through contract) providing Short-Doyle/Medi-Cal services have met applicable professional licensure requirements pursuant to Business and Professions and Welfare and Institutions Codes.

III. CONFIDENTIALITY

Contractor shall conform to and County shall monitor compliance with all State of California and Federal statutes and regulations regarding confidentiality, including but not limited to confidentiality of information requirements at 42, Code of Federal Regulations sections 2.1 *et seq*; California Welfare and Institutions Code, sections 14100.2, 11977, 11812, 5328; Division 10.5 and 10.6 of the California Health and Safety Code; Title 22, California Code of Regulations, section 51009; and Division 1, Part 2.6, Chapters 1-7 of the California Civil Code.

IV. NON-DISCRIMINATION

a. Eligibility for Services

Contractor shall prepare and make available to County and to the public all eligibility requirements to participate in the program plan set forth in the Agreement. No person shall, because of ethnic group identification, age, gender, color, disability, medical condition, national origin, race, ancestry, marital status, religion, religious creed, political belief or sexual preference be excluded from participation, be denied benefits of, or be subject to discrimination under any program or activity receiving Federal or State of California assistance.

b. Employment Opportunity

Contractor shall comply with County policy, and the Equal Employment Opportunity Commission guidelines, which forbids discrimination against any person on the grounds of race, color, national origin, sex, religion, age, disability status, or sexual preference in employment practices. Such practices include

retirement, recruitment advertising, hiring, layoff, termination, upgrading, demotion, transfer, rates of pay or other forms of compensation, use of facilities, and other terms and conditions of employment.

c. Suspension of Compensation

If an allegation of discrimination occurs, County may withhold all further funds, until Contractor can show clear and convincing evidence to the satisfaction of County that funds provided under this Agreement were not used in connection with the alleged discrimination.

d. Nepotism

Except by consent of County's Department of Behavioral Health Director, or designee, no person shall be employed by Contractor who is related by blood or marriage to, or who is a member of the Board of Directors or an officer of Contractor.

V. PATIENTS' RIGHTS

Contractor shall comply with applicable laws and regulations, including but not limited to, laws, regulations, and State policies relating to patients' rights.

STATE CONTRACTOR CERTIFICATION CLAUSES

I. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the non-discrimination program requirements. (Gov. Code§ 12990 (a-f) and CCR, Title 2, Section 111 02) (Not applicable to public entities.)

II. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.
    i. Establish a Drug-Free Awareness Program to inform employees about:
    ii. the dangers of drug abuse in the workplace;
    iii. the person's or organization's policy of maintaining a drug-free workplace;
    iv. any available counseling, rehabilitation and employee assistance programs; and,

v. penalties that may be imposed upon employees for drug abuse violations.

b. Every employee who works on this Agreement will:

i. receive a copy of the company's drug-free workplace policy statement; and,

ii. agree to abide by the terms of the company's statement as a condition of employment on this Agreement.

Failure to comply with these requirements may result in suspension of payments under this Agreement or termination of this Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

III. **NATIONAL LABOR RELATIONS BOARD CERTIFICATION**: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two (2) year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

IV. **CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT:** Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

V. **EXPATRIATE CORPORATIONS:** Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

VI. **SWEATFREE CODE OF CONDUCT:**

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. Contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. Contractor agrees to cooperate fully in providing reasonable access to the Contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the Contractor's compliance with the requirements under paragraph (a).

VII. **DOMESTIC PARTNERS:** For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code Section 10295.3.

VIII. **GENDER IDENTITY:** For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code Section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

I. **CONFLICT OF INTEREST:** Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with this Agreement, the awarding agency shall be contacted immediately for clarification.

a. **Current State Employees (Pub. Contract Code §10410):**

i. No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

ii. No officer or employee shall contract on their own behalf as an independent Contractor with any state agency to provide goods or services.

b. **Former State Employees (Pub. Contract Code §10411):**

i. For the two (2) year period from the date they left state employment, no former state officer or employee may enter into a contract in which they engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

ii. For the twelve (12) month period from the date they left state employment, no former state officer or employee may enter into a contract with any state agency if they were employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the twelve (12) month period prior to them leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)
Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

II. **LABOR CODE/WORKERS' COMPENSATION:** Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

III. **AMERICANS WITH DISABILITIES ACT:** Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

IV. **CONTRACTOR NAME CHANGE:** An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

V. **CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:**

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the Contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.
b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate Contractor performing within the state not be subject to the franchise tax.
c. Both domestic and foreign corporations (those incorporated outside of California) shall be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

VI. **RESOLUTION:** A County, city, district, or other local public body shall provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body, which by law has authority to enter into an agreement, authorizing execution of the agreement.

VII. **AIR OR WATER POLLUTION VIOLATION**: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code

for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

VIII. **PAYEE DATA RECORD FORM STD. 204**: This form shall be completed by all Contractors that are not another state agency or other governmental entity.

IX. **INSPECTION AND AUDIT OF RECORDS AND ACCESS TO FACILITIES:**

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of Contractor or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

a. Federal database checks

Consistent with the requirements at § 455.436 of this chapter, the State shall confirm the identity and determine the exclusion status of Contractor, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of Contractor through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases shall be consulted upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it shall promptly notify the Contractor and take action consistent with § 438.610(c).

The State shall ensure that Contractor with which the State contracts under this part is not located outside of the United States and that no claims paid by a Contractor to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CAL-AIM) REQUIREMENTS

I. SERVICES AND ACCESS PROVISIONS

a. **Certification of Eligibility**

i. Contractor will, in cooperation with County, comply with Section 14705.5 of California Welfare and Institutions Code to obtain a certification of an individual's eligibility for Specialty Mental Health Services (SMHS) under Medi-Cal.

b. **Access to Specialty Mental Health Services**

i. In collaboration with the County, Contractor will work to ensure that individuals to whom the Contractor provides SMHS meet access criteria, as per Department of Health Care Services (DHCS) guidance specified in Behavioral Health Information Notice (BHIN) 21-073. Specifically, the Contractor will ensure that the clinical record for each individual includes information as a whole indicating that individual's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below.

ii. For enrolled individuals under 21 years of age, Contractor shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled individuals who meet either of the following criteria, (I) or (II) below. If an individual under age 21 meets the criteria as described in (I) below, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (b) below.

1. The individual 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 DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

2. The individual has at least one of the following:

a. A significant impairment
b. A reasonable probability of significant deterioration in an important area of life functioning
c. A reasonable probability of not progressing developmentally as appropriate.
d. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal Managed Care Plan (MCP) is required to provide.

AND the individual's condition as described in subparagraph (II a-d) above is due to one of the following:

a. A diagnosed mental health disorder, according to the criteria in the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases and Related Health Problems (ICD).
b. A suspected mental health disorder that has not yet been diagnosed.
c. Significant trauma placing the individual at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

iii. For individuals 21 years of age or older, Contractor shall provide covered SMHS for persons served who meet both of the following criteria, (a) and (b) below:

1. The individual 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.
2. The individual's condition as described in paragraph (a) is due to either of the following:
   a. A diagnosed mental health disorder, according to the criteria in the current editions of the DSM and ICD.

b. A suspected mental disorder that has not yet been diagnosed.

c. **Additional Clarifications**

i. Criteria

1. A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service listed within Exhibit A of this Agreement can be provided and submitted to the County for reimbursement under any of the following circumstances:

a. The services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process;

b. The service was not included in an individual treatment plan; or

c. The individual had a co-occurring substance use disorder.

ii. Diagnosis Not a Prerequisite

1. Per BHIN 21-073, a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a current Centers for Medicare & Medicaid Services (CMS) approved ICD diagnosis code

d. **Medical Necessity**

i. Contractor will ensure that services provided are medically necessary in compliance with BHIN 21-073 and pursuant to Welfare and Institutions Code section 14184.402(a). Services provided to a person served shall be medically necessary and clinically appropriate to address the individual's presenting condition. Documentation in each individual's chart as a whole will demonstrate medical necessity as defined below, based on the age of the individual at the time of service provision.

ii. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant

disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

iii. For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

e. **Coordination of Care**

i. Contractor shall ensure that all care, treatment and services provided pursuant to this Agreement are coordinated among all providers who are serving the individual, including all other SMHS providers, as well as providers of Non-Specialty Mental Health Services (NSMHS), substance use disorder treatment services, physical health services, dental services, regional center services and all other services as applicable to ensure a person served-centered and whole-person approach to services.

ii. Contractor shall ensure that care coordination activities support the monitoring and treatment of comorbid substance use disorder and/or health conditions.

iii. Contractor shall include in care coordination activities efforts to connect, refer and link individual s to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

iv. Contractor shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.

v. To facilitate care coordination, Contractor will request a HIPAA and California law compliant person served authorization to share the individual’s information with and among all other providers involved in the individual’s care, in satisfaction of state and federal privacy laws and regulations.

f. **Co-Occurring Treatment and No Wrong Door**

i. Per BHIN 22-011, Specialty and Non-Specialty Mental Health Services can be provided concurrently, if those services are clinically

appropriate, coordinated, and not duplicative. When a person served meets criteria for both NSMHS and SMHS, the individual should receive services based on individual clinical need and established therapeutic relationships. Clinically appropriate and covered SMHS can also be provided when the individual has a co-occurring mental health condition and substance use disorder.

ii. Under this Agreement, Contractor will ensure that individual s receive timely mental health services without delay. Services are reimbursable to Contractor by County even when:

1. Services are provided prior to determination of a diagnosis, during the assessment or prior to determination of whether SMHS access criteria are met, even if the assessment ultimately indicates the individual does not meet criteria for SMHS.
2. If Contractor is serving an individual receiving both SMHS and NSMHS, Contractor holds responsibility for documenting coordination of care and ensuring that services are non-duplicative.

II. AUTHORIZATION AND DOCUMENTATION PROVISIONS

a. Service Authorization

i. Contractor will collaborate with County to complete authorization requests in line with County and DHCS policy.

ii. Contractor shall have in place, and follow, written policies and procedures for completing requests for initial and continuing authorizations of services, as required by County guidance.

iii. Contractor shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.

iv. County shall provide Contractor with written notice of authorization determinations within the timeframes set forth in BHINs 22-016 and 22-017, or any subsequent DHCS notices.

v. Contractor shall alert County when an expedited authorization decision (no later than 72 hours) is necessary due to an individual's specific

needs and circumstances that could seriously jeopardize the individual s life or health, or ability to attain, maintain, or regain maximum function.

b. **Documentation Requirements**

i. Contractor will follow all documentation requirements as specified in Exhibit B - Attachment C, titled “Documentation Standards for Person Served Records”, which includes compliance with federal, state and County requirements.

ii. All Contractor documentation shall be accurate, complete, and legible, shall list each date of service, and include the face-to-face time for each service. Contractor shall document travel and documentation time for each service separately from face-to-face time and provide this information to County upon request. Services shall be identified as provided in-person, by telephone, or by telehealth.

iii. All services shall be documented utilizing County-approved templates and contain all required elements. Contractor agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this Article require corrective action plans.

c. **Assessment**

i. Contractor shall ensure that all individuals’ medical records include an assessment of each individual's need for mental health services.

ii. Contractor will utilize the seven uniform assessment domains and include other required elements as identified in BHIN 22-019 and document the assessment in the individual’s medical record.

iii. For individual s aged 6 through 20, the Child and Adolescent Needs and Strengths (CANS), and for individual s aged 3 through 18, the Pediatric Symptom Checklist-35 (PSC-35) tools are required at intake, every six months during treatment, and at discharge, as specified in DHCS MHSUDS INs 17-052 and 18-048.

iv. The time period for providers to complete an initial assessment and subsequent assessments for SMHS are up to clinical discretion of County; however, Contractor’s providers shall complete assessments

within a reasonable time and in accordance with generally accepted standards of practice.

d. **ICD-10**

i. Contractor shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.

ii. Once a DSM diagnosis is determined, the Contractor shall determine the corresponding mental health diagnosis in the current edition of ICD. Contractor shall use the ICD diagnosis code(s) to submit a claim for SMHS to receive reimbursement from County.

iii. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by CMS

e. **Problem List**

i. Contractor will create and maintain a Problem List for each individual served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

ii. Contractor shall document a problem list that adheres to industry standards utilizing at minimum current SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2022 Release, and ICD-10-CM 2023.

iii. A problem identified during a service encounter may be addressed by the service provider during that service encounter and subsequently added to the problem list.

iv. The problem list shall include, but is not limited to, all elements specified in BHIN 22-019.

v. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Contractor shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the person

served, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

f. **Treatment and Care Plans**

i. Contractor is not required to complete treatment or care plans for persons served under this Agreement, except in the circumstances specified in BHIN 22-019 and additional guidance from DHCS that may follow after execution of this Agreement.

g. **Progress Notes**

i. Contractor shall create progress notes for the provision of all SMHS services provided under this Agreement.

ii. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

iii. Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or a group service.

iv. Contractor shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

v. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services, if applicable.

h. **Transition of Care Tool**

i. Contractor shall use a Transition of Care Tool for any individual whose existing services will be transferred from Contractor to an Medi-Cal Managed Care Plan (MCP) provider or when NSMHS will be added to the existing mental health treatment provided by Contractor, as specified in BHIN 22-065, in order to ensure continuity of care.

ii. Determinations to transition care or add services from an MCP shall be made in alignment with County policies and via a person-centered, shared decision-making process.

iii. Contractor may directly use the DHCS-provided Transition of Care Tool, found at https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx, or obtain a copy of that tool provided by the County. Contractor may

create the Transition of Care Tool in its Electronic Health Record (EHR). However, the contents of the Transition of Care Tool, including the specific wording and order of fields, shall remain identical to the DHCS provided form. The only exception to this requirement is when the tool is translated into languages other than English.

i. **Telehealth**

i. Contractor may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.

ii. All telehealth equipment and service locations shall ensure that person served confidentiality is maintained.

iii. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.

iv. Medical records for individuals served by Contractor under this Agreement shall include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Contractor. Such consent shall be obtained at least once prior to initiating applicable health care services and consent shall include all elements as specified in BHIN 22-019.

v. County may at any time audit Contractor's telehealth practices, and Contractor shall allow access to all materials needed to adequately monitor Contractor's adherence to telehealth standards and requirements.

III. PROTECTIONS FOR PERSONS SERVED

a. **Grievances, Appeals, and Notices of Adverse Benefit Determination**

i. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Contractor shall be immediately forwarded to the County's

DBH Plan Administration Division or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the DBH Plan Administration staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.

ii. Contractor shall not discourage the filing of grievances and individual s do not need to use the term “grievance” for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.

iii. Aligned with MHSUDS IN 18-010E and 42 C.F.R. §438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) shall be issued by Contractor within the specified timeframes using the template provided by the County.

iv. NOABDs shall be issued to individuals anytime the Contractor has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice shall have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Contractor shall inform the County immediately after issuing a NOABD.

v. Procedures and timeframes for responding to grievances, issuing and responding to adverse benefit determinations, appeals, and state hearings shall be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).

vi. Contractor shall provide individuals any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.

vii. Contractor shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures. The record shall be accurately maintained in a manner accessible to the County and available upon request to DHCS.

b. **Advanced Directives**

i. Contractor shall comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6(i) (l), (3) and (4).

c. **Continuity of Care**

i. Contractor shall follow the County's continuity of care policy that is in accordance with applicable state and federal regulations, MHSUDS IN 18-059 and any BHINs issued by DHCS for parity in mental health and substance use disorder benefits subsequent to the effective date of this Agreement (42 C.F.R. § 438.62(b)(1)-(2).)

IV. QUALITY IMPROVEMENT PROGRAM

a. **Quality Improvement Activities and Participation**

i. Contractor shall implement mechanisms to assess person served/family satisfaction based on County's guidance. The Contractor shall assess individual/family satisfaction by:

1. Surveying person served/family satisfaction with the Contractor's services at least annually.
2. Evaluating grievances of the person served, appeals and State Hearings at least annually.
3. Evaluating requests to change persons providing services at least annually.
4. Informing the County and individuals of the results of persons served/family satisfaction activities.

ii. Contractor, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually and as required by DBH.

iii. Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually and shared with the County.

iv. Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.

v. Contractor shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed.

The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.

vi. Contractor shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Contractor shall ensure that there is active participation by the Contractor's practitioners and providers in the QIC.

vii. Contractor shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

b. **Timely Access**

i. Timely access standards include:

1. Contractor shall have hours of operation during which services are provided to Medi-Cal individuals that are no less than the hours of operation during which the provider offers services to non-Medi-Cal individual s. If the Contractor's provider only serves Medi-Cal beneficiaries, the provider shall provide hours of operation comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Agreement or another County.
2. Appointments data, including wait times for requested services, shall be recorded and tracked by Contractor, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Planning and Quality Management Division or other designated persons.
3. Urgent care appointments for services that do not require prior authorization shall be provided to individual s within 48 hours of a request. Urgent appointments for services that do require prior authorization shall be provided to persons served within 96 hours of request.

4. Non-urgent non-psychiatry mental health services, including, but not limited to Assessment, Targeted Case Management, and Individual and Group Therapy appointments (for both adult and children/youth) shall be made available to Medi-Cal individuals within 10 business days from the date the individual or a provider acting on behalf of the individual, requests an appointment for a medically necessary service. Non-urgent psychiatry appointments (for both adult and children/youth) shall be made available to Medi-Cal individual s within 15 business days from the date the person served or a provider acting on behalf of the individual, requests an appointment for a medically necessary service.
5. Applicable appointment time standards may be extended if the referring or treating provider has determined and noted in the individual's record that a longer waiting period will not have a detrimental impact on the health of the individual.
6. Periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of their practice.

c. **Provider Application and Validation for Enrollment (PAVE)**

i. Contractor shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal individuals on behalf of Contractor, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to BHIN 20-071 requirements, the 21st Century Cures Act and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.

ii. SMHS licensed individuals required to enroll via the "Ordering, Referring and Prescribing" (ORP) PAVE enrollment pathway (i.e. PAVE application package) available through the DHCS PED Pave Portal, include: Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC), Psychologist, Licensed Educational Psychologist,

Physician (MD and DO), Physician Assistant, Registered Pharmacist/Pharmacist, Certified Pediatric/Family Nurse Practitioner, Nurse Practitioner, Occupational Therapist, and Speech-Language Pathologist. Interns, trainees, and associates are not eligible for enrollment.

d. **Physician Incentive Plan**

i. If Contractor wants to institute a Physician Incentive Plan, Contractor shall submit the proposed plan to the County which will in turn submit the Plan to the State for approval, in accordance with the provisions of 42 C.F.R. § 438.6(c).

V. DATA, PRIVACY AND SECURITY REQUIREMENTS

a. **Electronic Privacy and Security**

i. Contractor shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. Contractor's email transmissions shall display a warning banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.

ii. Contractor shall institute compliant password management policies and procedures, which shall include but not be limited to procedures for creating, changing, and safeguarding passwords. Contractor shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.

iii. Any Electronic Health Records (EHRs) maintained by Contractor that contain PHI or PII for individuals served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Contractors that utilize an EHR shall maintain all parts of the clinical record that are not stored in the EHR, including but not limited to the following examples of person served signed documents: discharge plans, informing materials, and health questionnaire.

iv. Contractor entering data into any County electronic systems shall ensure that staff are trained to enter and maintain data within this system.

VI. PROGRAM INTEGRITY

a. **Credentialing and Re-credentialing of Providers**

i. Contractor shall ensure that all of their network providers delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony convictions;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness

ii. Contractor shall file and keep track of attestation statements, credentialing applications and credentialing status for all of their providers and shall make those available to the County upon request at any time.

iii. Contractor is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.

ELECTRONIC HEALTH RECORD REQUIREMENTS AND SERVICE DATA

Contractor will provide accurate and timely input of services provided in the County's Electronic Health Record (EHR). The current EHR is a web-based application and requires a computer with a minimum of 16 GB RAM using either Edge or Chrome as the browser, and a stable high speed internet connection. Additional drivers may be needed to scan documents into the EHR. Contractor will be responsible for equipment to support the using of the EHR. Contractor may be required to utilize data entry forms, portals, or related systems for compliance with County data reporting requirements during the duration of this Agreement.

Data entry shall be the responsibility of the Contractor. The County shall monitor the number and amount of services entered into the EHR. Any and all audit exceptions resulting from the provision and billing of Medi-Cal services by the Contractor shall be the sole responsibility of the Contractor.

Contractor will utilize the County's EHR for all Behavioral Health Plan billing and reporting functions and may elect to utilize the County's EHR for all clinical documentation, at no additional cost to Contractor.

If Contractor elects to not use the County's EHR for all clinical documentation, the Contractor must ensure all necessary requirements involving electronic health information exchange between the Contractor and the County will be met.

FRESNO COUNTY BEHAVIORAL HEALTH PLAN
COMPLIANCE PROGRAM CODE OF CONDUCT

All Fresno County Behavioral/Mental Health Employees, Contractors (including Contractor's Employees/Subcontractors), Volunteers and Students will:

I. Read, acknowledge, and abide by this Code of Conduct.

II. Be responsible for reviewing and understanding Compliance Program policies and procedures including the possible consequences for failure to comply or failure to report such non-compliance.

III. NOT engage in any activity in violation of the County's Compliance Program, nor engage in any other conduct which violates any applicable law, regulation, rule, or guideline. Conduct yourself honestly, fairly, courteously, and with a high degree of integrity in your professional dealings related to your employment/contract with the County and avoid any conduct that could reasonably be expected to reflect adversely upon the integrity of the County and the services it provides.

IV. Practice good faith in transactions occurring during the course of business and never use or exploit professional relationships or confidential information for personal purposes.

V. Promptly report any activity or suspected violation of the Code of Conduct, the policies and procedures of the County, the Compliance Program, or any other applicable law, regulation, rule or guideline. All reports may be made anonymously. Fresno County prohibits retaliation against any person making a report. Any person engaging in any form of retaliation will be subject to disciplinary or other appropriate action by the County.

VI. Comply with not only the letter of Compliance Program and behavioral health policies and procedures, but also with the spirit of those policies and procedures as well as other rules or guidelines adopted by the County. Consult with your supervisor or the Compliance Office regarding any Compliance Program standard or other applicable law, regulation, rule or guideline.

VII. Comply with all laws governing the confidentiality and privacy of information. Protect and retain records and documents as required by County contract/standards, professional standards, governmental regulations, or organizational policies.

VIII. Comply with all applicable laws, regulations, rules, guidelines, and County policies and procedures when providing and billing behavioral health services. Bill only for eligible services actually rendered and fully documented. Use billing codes that accurately describe the services provided. Ensure that no false, fraudulent, inaccurate, or fictitious claims for

payment or reimbursement of any kind are prepared or submitted. Ensure that claims are prepared and submitted accurately and timely and are consistent with all applicable laws, regulations, rules and guidelines. Act promptly to investigate and correct problems if errors in claims or billings are discovered.

IX. Immediately notify your supervisor, Department Head, Administrator, or the Compliance Office if you become or may become an Ineligible/Excluded Person and therefore excluded from participation in the Federal health care programs.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) BUSINESS ASSOCIATE AGREEMENT

I. County is a "Covered Entity," and Contractor is a "Business Associate," as these terms are defined by 45 CFR 160.103. In connection with providing services under the Agreement, the parties anticipate that Contractor will create and/or receive Protected Health Information ("PHI") from or on behalf of County. The parties enter into this Business Associate Agreement (BAA) to comply with the Business Associate requirements of HIPAA, to govern the use and disclosures of PHI under this Agreement. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Parts 160 and 164.

The parties to this Agreement shall be in strict conformance with all applicable federal and State of California laws and regulations, including, but not limited to California Welfare and Institutions Code sections 5328, 10850, and 14100.2 et seq.; 42 CFR 2; 42 CFR 431; California Civil Code section 56 et seq.; the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), including, but not limited to, 45 CFR Parts160, 45 CFR 162, and 45 CFR 164; the Health Information Technology for Economic and Clinical Health Act ("HITECH") regarding the confidentiality and security of patient information, including, but not limited to 42 USC 17901 *et seq.*; and the Genetic Information Nondiscrimination Act ("GINA") of 2008 regarding the confidentiality of genetic information.

Except as otherwise provided in this Agreement, Contractor, as a business associate of County, may use or disclose Protected Health Information ("PHI") to perform functions, activities or services for or on behalf of County, as specified in this Agreement, provided that such use or disclosure shall not violate HIPAA Rules. The uses and disclosures of PHI may not be more expansive than those applicable to County, as the "Covered Entity" under the HIPAA Rules, except as authorized for management, administrative or legal responsibilities of Contractor.

II. Contractor shall protect, from unauthorized access, use, or disclosure of names and other identifying information concerning persons receiving services pursuant to this Agreement, except where permitted in order to carry out data aggregation purposes for health care operations. (45 CFR Sections 164.504 (e)(2)(i), 164.504 (3)(2)(ii)(A), and 164.504 (e)(4)(i).) This pertains to any and all persons receiving services pursuant to a County funded program. Contractor shall not use such identifying information for any purpose other than carrying out Contractor's obligations under this Agreement.

III. Contractor shall not disclose any such identifying information to any person or entity, except as otherwise specifically permitted by this Agreement, authorized by law, or authorized by the client/patient.

IV. For purposes of the above sections, identifying information shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print, or a photograph.

V. Contractor shall provide access, at the request of County, and in the time and manner designated by County, to PHI in a designated record set (as defined in 45 CFR Section 164.501), to an individual or to County in order to meet the requirements of 45 CFR Section164.524 regarding access by individuals to their PHI.

Contractor shall make any amendment(s) to PHI in a designated record set at the request of County, and in the time and manner designated by County in accordance with 45 CFR Section 164.526.

Contractor shall provide to County or to an individual, in a time and manner designated by County, information collected in accordance with 45 CFR Section 164.528, to permit County to respond to a request by the individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

VI. Contractor shall report to County, in writing, any knowledge or reasonable belief that there has been unauthorized access, viewing, use, disclosure, or breach of PHI not permitted by this Agreement, and any breach of unsecured PHI of which it becomes aware, immediately and without reasonable delay and in no case later than two (2) business days of discovery. Immediate notification shall be made to County's Information Security Officer and Privacy Officer and DBH's HIPAA Representative, within two (2) business days of discovery. The notification shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, disclosed, or breached. Contractor shall take prompt corrective action to cure any deficiencies and any action pertaining to such unauthorized disclosure required by applicable Federal and State Laws and regulations. Contractor shall investigate such breach and is responsible for all notifications required by law and regulation or deemed necessary by County and shall provide a written report of the investigation and reporting required to County's Information Security Officer and Privacy Officer and DBH's HIPAA Representative.

This written investigation and description of any reporting necessary shall be postmarked within the thirty (30) working days of the discovery of the breach to the addresses below:

County of Fresno	County of Fresno	County of Fresno
Department of Public Health	Department of Public Health	Office of Information Security
HIPAA Representative	Privacy Officer	Chief Information Security Officer
(559) 600-6439	(559) 600-6405	(559) 600-5810
P.O. Box 11867	P.O. Box 11867	333 W. Pontiac Way
Fresno, California 93775	Fresno, California 93775	Clovis CA, 93612

VII. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from County, or created or received by Contractor on behalf of County, available to the United States Department of Health and Human Services upon demand.

VIII. Safeguards

Contractor shall implement administrative, physical, and technical safeguards as required by 45 CFR 164.308, 164.310, and 164.312 that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of County; and to prevent access, use or disclosure of PHI other than as provided for by this Agreement. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of Contractor's operations and the nature and scope of its activities. Upon County's request, Contractor shall provide County with information concerning such safeguards.

Contractor shall implement strong access controls and other security safeguards and precautions in order to restrict logical and physical access to confidential, personal (e.g., PHI) or sensitive data to authorized users only.

IX. Mitigation of Harmful Effects

Contractor shall mitigate, to the extent practicable, any harmful effect that is known to Contractor of an unauthorized access, viewing, use, disclosure, or breach of PHI by Contractor or its subcontractors in violation of the requirements of these provisions.

X. Contractor's Subcontractors

Contractor shall ensure that any of its subcontractors, if applicable, to whom Contractor provides PHI received from or created or received by Contractor on behalf of County, agree to the same restrictions and conditions that apply to Contractor with respect to such PHI; and to incorporate, when applicable, the relevant provisions of these provisions into each subcontract or sub-award to such subcontractors.

XI. Effect of Termination

Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all PHI received from County (or created or received by Contractor on behalf of County) that Contractor still maintains in any form, and shall retain no copies of such PHI. If return or destruction of PHI is not feasible, it shall continue to extend the protections of these provisions to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents, if applicable, of Contractor. If Contractor destroys the PHI data, a certification of date and time of destruction shall be provided to County by Contractor.

XII. Interpretation

The terms and conditions in these provisions shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA regulations and applicable State laws. The parties agree that any ambiguity in the terms and conditions of these provisions shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA regulations.

XIII. Regulatory References

A reference in the terms and conditions of these provisions to a section in the HIPAA regulations means the section as in effect or as amended.

XIV. Survival

The respective rights and obligations of Contractor as stated in this Section shall survive the termination or expiration of this Agreement.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Case for the Enhanced National CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

Bibliography:

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Powe, N.R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E008-02). Retrieved from the Agency of Healthcare Research and Quality website: http://www.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). The economic burden of health inequalities in the United States. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf

National Partnership for Action to End Health Disparities. (2011). National stakeholder strategy for achieving health equity. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). Healthy people 2020: Social determinants of health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

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World Health Organization. (2012). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/

FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
FINANCIAL TERMS AND CONDITIONS

This Exhibit sets forth the financial terms and conditions, including compensation, invoicing, billing, audits, and other fiscal requirements, and is incorporated into the Specialty Mental Health Services (SMHS) Agreement between County and Contractor. County shall ensure timely and accurate compensation for services delivered and fulfill all responsibilities associated with funding sources under this Agreement.

I. Compensation

County shall compensate Contractor for services rendered under this Agreement, subject to the limitations and conditions herein. Compensation under this Agreement shall be paid only for services performed in accordance with its terms, while the Agreement is in effect, and subject to the amounts stated in this section. County employees have no authority to authorize payment beyond what is expressly provided in this Agreement.

a. Total Maximum Compensation

In no event shall total compensation payable to Contractor for all services provided under this Agreement exceed Thirty-Two Million One Hundred Thirty-One Thousand Two Hundred Forty-Six and 50/100 Dollars ($32,131,246.50), during the entire term of this Agreement.

The maximum compensation may be increased only through a written amendment, contingent on the availability of sufficient funds.

Fiscal Year (FY)	FSP SMHS Maximum Compensation	ICM SMHS Maximum Compensation	FSP ICM SMHS Maximum Compensation	OP SMHS Maximum Compensation	Non-Treatment Maximum Compensation (MHSA/BHSA) WIT	AOT FY Maximum Compensation	CARE Act FY Maximum Compensation	CARE Act Person Served Incentives	Total FY Maximum Compensation
FY 2025-26	$3,436,891	$270,318	$0	$154,467	$751,529	$83,333	$154,658.50	$4,000	$4,855,196.50
FY 2026-27	$0	$0	$4,200,000	$190,921	$200,000	$100,000	$264,000	$48,000	$5,002,921
FY 2027-28	$0	$0	$5,410,000	$196,482	$250,000	$100,000	$264,000	$48,000	$6,268,482

FY 2028-29	$0	$0	$6,684,000	$202,043	$300,000	$100,000	$264,000	$48,000	$7,598,043
FY 2029-30	$0	$0	$7,462,000	$207,604	$325,000	$100,000	$264,000	$48,000	$8,406,604
	$3,436,891	$270,318	$23,756,000	$951,517	$1,826,529	$483,333	$1,210,658.50	$196,000	$32,131,246.50

b. Maximum Compensation for SMHS

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for SMHS shall be as follows:

September 1, 2025 – June 30, 2026: Three Million Eight Hundred Sixty-One Thousand Six Hundred Seventy-Six and No/100 Dollars ($3,861,676)

July 1, 2026 – June 30, 2027: Four Million Three Hundred Ninety Thousand Nine Hundred Twenty-One and No/100 Dollars ($4,390,921.00)

July 1, 2027 – June 30, 2028: Five Million Six Hundred Six Thousand Four Hundred Eighty-Two and No/100 Dollars ($5,606,482.00)

July 1, 2028 – June 30, 2029: Six Million Eight Hundred Eighty-Six Thousand Forty-Three and No/100 Dollars ($6,886,043.00)

July 1, 2029 – June 30, 2030: Seven Million Six Hundred Sixty-Nine Thousand Six Hundred Four and No/100 Dollars ($7,669,604.00)

This amount is not guaranteed and shall be paid only for approved services rendered and claims submitted and approved through the Electronic Health Record (EHR).

c. Maximum Compensation for Non-Treatment Supports

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for non-treatment supports shall be as follows:

September 1, 2025 – June 30, 2026: Seven Hundred Fifty-One Thousand Five Hundred Twenty-Nine and No/100 Dollars ($751,529.00)

July 1, 2026 – June 30, 2027: Two Hundred Thousand and No/100 Dollars ($200,000.00)

July 1, 2027 – June 30, 2028: Two Hundred Fifty Thousand and No/100 Dollars ($250,000.00)

July 1, 2028 – June 30, 2029: Three Hundred Thousand and No/100 Dollars ($300,000.00)

July 1, 2029 – June 30, 2030: Three Hundred Twenty-Five Thousand and No/100 Dollars ($325,000.00)

These amounts will be reimbursed based on actual costs in accordance with the approved budget in Revised Exhibit C – Attachment B, up to the FY maximum listed above.

d. Maximum Compensation for Assisted Outpatient Treatment (AOT)

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for AOT services shall be as follows:

September 1, 2025 – June 30, 2026: Eighty-Three Thousand, Three Hundred Thirty-Three and No/100 Dollars ($83,333.00)

July 1, 2026 – June 30, 2027: One Hundred Thousand and No/100 Dollars ($100,000.00)

July 1, 2027 – June 30, 2028: One Hundred Thousand and No/100 Dollars ($100,000.00)

July 1, 2028 – June 30, 2029: One Hundred Thousand and No/100 Dollars ($100,000.00)

July 1, 2029 – June 30, 2030: One Hundred Thousand and No/100 Dollars ($100,000.00)

This amount is not guaranteed and shall be paid only for approved services rendered and approved through the Electronic Health Record (EHR).

e. Maximum Compensation for Community Assistance, Recovery and Empowerment (CARE) Act

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for CARE Act services shall be as follows:

September 1, 2025 – June 30, 2026: One Hundred Fifty-Four Thousand Six Hundred Fifty-Eight and 50/100 Dollars ($154,658.50)

July 1, 2026 – June 30, 2027: Two Hundred Sixty-Four Thousand and No/100 Dollars ($264,000.00)

July 1, 2027 – June 30, 2028: Two Hundred Sixty-Four Thousand and No/100 Dollars ($264,000.00)

July 1, 2028 – June 30, 2029: Two Hundred Sixty-Four Thousand and No/100 Dollars ($264,000.00)

July 1, 2029 – June 30, 2030: Two Hundred Sixty-Four Thousand and No/100 Dollars ($264,000.00)

This amount is not guaranteed and shall be paid only for approved services rendered and claims submitted and approved through the Electronic Health Record (EHR).

f. Maximum Compensation for Community Assistance, Recovery and Empowerment (CARE) Act Incentives

For each fiscal year covered by this Agreement, the maximum compensation payable to Contractor for CARE Act incentives shall be as follows:

September 1, 2025 – June 30, 2026: Four Thousand and No/100 Dollars ($4,000.00)
July 1, 2026 – June 30, 2027: Forty-Eight Thousand and No/100 Dollars ($48,000.00)
July 1, 2027 – June 30, 2028: Forty-Eight Thousand and No/100 Dollars ($48,000.00)
July 1, 2028 – June 30, 2029: Forty-Eight Thousand and No/100 Dollars ($48,000.00)
July 1, 2029 – June 30, 2030: Forty-Eight Thousand and No/100 Dollars ($48,000.00)

These amounts will be reimbursed based on actual costs in accordance with the approved budget in Revised Exhibit C – Attachment B, up to the FY maximum listed above.

II. Performance Incentives for SMHS Fee-For-Service

Contractor may be eligible to receive performance-based incentives intended to encourage program growth, enhance service delivery, and improve overall wellness outcomes in unserved and underserved communities. The determination of eligibility and the calculation of such incentives shall be at the discretion of County's DBH Director or designee and governed by the following conditions:

a. Eligibility

i. Incentives shall be available only after the completion of two full fiscal years under this Agreement for Contractors providing SMHS reimbursed under County's Fee-for-Service structure.

ii. A baseline cannot be established using partial fiscal year data; therefore, eligibility requires two consecutive complete fiscal years of performance data.

iii. Contractors entering this Agreement after the initial contract fiscal year shall become eligible upon completion of two consecutive fiscal years under this Agreement.

b. Performance Baseline

i. The initial performance baseline shall be established based on the Contractor's State-approved claimed dollar amount for services performed, claimed, and approved by the State in fiscal year one (1), as recorded by County.

ii. This baseline shall be adjusted for any subsequent State rate changes to finalize the performance baseline for fiscal year two (2).

c. Incentive Calculation

i. Upon completion of fiscal year two (2), if Contractor exceeds the established performance baseline, Contractor shall be eligible for an incentive payment equal to eight percent (8%) of the Medi-Cal reimbursements generated above the baseline amount.

d. Annual Adjustments

i. Each subsequent fiscal year's performance baseline shall be adjusted annually to the higher of:

1. The prior fiscal year's actual State-approved claimed amount plus any State rate increases; or
2. The previously established performance baseline amount plus any State rate increases.

ii. Under no circumstances shall the performance baseline decrease from one fiscal year to the next.

e. Illustrative Table

The table below provides an example of annual baseline adjustments. This table is for reference only and is not binding. Actual details will be finalized between both parties at the conclusion of fiscal year one (1).

Fiscal Year	Prior Baseline (Before Adjustment)	State Rate Adjustment	New Performance Baseline	Actual Claimed Amount	Amount Above Baseline	Performance Incentive (8%)

			(After Adjustment)			
Year 1	N/A	N/A	N/A	$500,000	$0	$0
Year 2	$500,000	+3%	$515,000	$550,000	$35,000	$2,800
Year 3	$550,000	+2%	$561,000	$520,000	$0	$0
Year 4	$561,000	+2%	$572,220	$600,000	$27,780	$2,222
Year 5	$600,000	+2%	$612,000	$650,000	$38,000	$3,040

Contractor must be in satisfactory standing with all performance outcomes and reporting requirements under this Agreement prior to receiving any performance-based incentive payment. All required reports must be submitted in full and on time. Failure to meet these requirements may result in County's DBH Director or designee, at their sole discretion, deeming Contractor ineligible for performance incentives or withhold payments until compliance is achieved.

County will calculate and provide written notification of any incentive award within ninety (90) calendar days after all State-approved claimed services for the targeted fiscal year have been received and recorded by County, or within nine (9) months following the end of the targeted fiscal year, whichever is later. Payment of any approved incentive will be made within forty-five (45) days after final approval.

Payment of performance incentives is contingent upon compliance with all applicable regulations and the availability of funds.

III. Rate Categories for Fee-For-Service

The Full-Service Partnership and Outpatient services provided by the Contractor under this Agreement shall be reimbursed in accordance with the rate schedule set forth in Exhibit C – Attachment A, which is incorporated herein by reference and made part of this Agreement. Services shall be categorized as Field-based, and the Contractor shall be compensated according to the applicable rate schedule specified in Exhibit C – Attachment A.

a. Clinic-Site Based:

Clinic-Site programs are defined as programs that provide less than fifty percent (50%) of services in the field. For purposes of this calculation, only billable services will be considered. "In the field" refers to services that do not occur through telehealth and do not occur at designated sites where Contractor is afforded regular access. Designated sites shall be

identified by Contractor and approved in writing by County's DBH Director or designee. County retains the sole discretion to classify a program as Clinic-Site Based.

For the purposes of this Agreement, Clinic-Site Based locations are defined as the following SmartCare (EHR) Locations (CMS Places of Service):

i. Office
ii. Telehealth Provided Other than in Persons Served Home
iii. Telehealth Provided in Patient's Home
iv. Any location where the mode of delivery is Video Conference, Telephone, or Written communication

These locations will be used to calculate the ratio of Clinic-Site Based to Field Based services.

b. Field Based:

Field Based programs are defined as programs that provide more than fifty percent (50%) of services in the field. "In the field" refers to services that do not occur through telehealth and do not occur at designated sites where the Contractor is afforded regular access. The County retains sole discretion to classify a program as Field-Based.

During the term of this Agreement, Contractor may submit a written proposal to County requesting compensation under the Field-Based reimbursement rate category. Such proposals must be submitted at least ninety (90) calendar days prior to the start of each new fiscal year. County shall provide a written decision prior to the start of the next fiscal year. If approved, County's DBH Director or designee will issue a rate change notification in accordance with the modification provisions of this Agreement, and Contractor's performance will be monitored for compliance with Field-Based service delivery requirements as outlined above.

If Contractor is deemed eligible to receive compensation at the Field-Based reimbursement rates and subsequently fails to meet the Field-Based service delivery requirements, Contractor shall be subject to recoupment of payments at the sole discretion of County's DBH Director or designee, upon written notice.

County shall complete Field-Based service delivery analysis and any recoupment reconciliation within ninety (90) calendar days following the end of the targeted quarter, or within ninety (90) calendar days after all billable services for that quarter have been entered into in the EHR by the Contractor, whichever is later. The recoupment amount shall equal the difference between payments made to Contractor during the targeted quarter and the amount recalculated at the respective fiscal year's Clinic-Site Based rate schedule, after applying any claiming adjustments. County shall provide written notice to Contractor of the analysis results and, if

applicable, process the recoupment in accordance with the terms and conditions of this Agreement.

County shall monitor Contractor on an ongoing basis and analyze data to ensure the accuracy of assigned rate categories. County retains authority to reassign rate categories as necessary and will provide written notice of any such changes in accordance with the modification provisions outlined in Article 15 of this Agreement. Contractor may appeal the category reassignment in writing within thirty (30) calendar days of receiving written notice. If no appeal is submitted within this timeframe, the reassignment will stand.

IV. Invoices

County shall process and pay Contractor's invoices for services rendered under this Agreement, subject to the limitations and conditions herein. Payment under this Agreement shall be made only for invoices submitted in accordance with its terms, while the Agreement is in effect, and subject to the deadlines and requirements stated in this section. County employees have no authority to authorize payment beyond what is expressly provided in this Agreement.

a. Definition of Acceptable Invoice

Definition

An Acceptable Invoice is a complete, itemized invoice submitted in accordance with the submission requirements set forth in Section IV(b) of this Exhibit. Each invoice shall include, at a minimum:

i. Contractor's legal name and remit-to address;
ii. Invoice number and date;
iii. Contract or Purchase Order (PO) number;
iv. Service period, including start and end dates;
v. Itemized description of services, including units, rates, and applicable codes;
vi. Total amount due, reflecting any credits or adjustments; and
vii. County department or cost center, if applicable.

b. Invoice Submission Deadlines

Contractor shall comply with the following requirements for invoice submission and processing:

i. Monthly Submission
    1. Contractor shall use best efforts to submit monthly invoices, in arrears, by the fifteenth (15th) calendar day of each month.

2. Invoices shall be submitted in the format prescribed by County. This timeline is intended to facilitate prompt processing and does not supersede the final submission deadline specified below.

ii. Submission Method

All invoices shall be submitted electronically to the following recipients:

3. dbhinvoicereview@fresnocountyca.gov
4. dbh-invoices@fresnocountyca.gov
5. County's assigned DBH Staff Analyst

iii. Illustrative Table

The table below provides an example of FY 2026-2027 invoice deadlines.

Service Month	Target Submission	Initial Invoice Deadline	Supplemental*/ OHC Deadline
Jul 2026	Aug 15, 2026	Sep 29, 2026	Nov 28, 2026
Aug 2026	Sep 15, 2026	Oct 30, 2026	Dec 29, 2026
Sep 2026	Oct 15, 2026	Nov 29, 2026	Jan 28, 2027
Oct 2026	Nov 15, 2026	Dec 30, 2026	Feb 28, 2027
Nov 2026	Dec 15, 2026	Jan 29, 2027	Mar 30, 2027
Dec 2026	Jan 15, 2027	Mar 01, 2027	Apr 30, 2027
Jan 2027	Feb 15, 2027	Apr 01, 2027	May 31, 2027
Feb 2027	Mar 15, 2027	Apr 29, 2027	Jun 28, 2027
Mar 2027	Apr 15, 2027	May 30, 2027	Jul 29, 2027
Apr 2027	May 15, 2027	Jun 29, 2027	Aug 28, 2027
May 2027	Jun 15, 2027	Jul 30, 2027	Supplemental – Aug 29, 2027 OHC – Sep 28, 2027
June 2027	Jul 15, 2027	Aug 29, 2027	Supplemental – Aug 29, 2027 OHC – Oct 28, 2027

*Supplemental allowed if initial invoice submission is timely

c. Invoice Review and Withholding

At the discretion of County, if an invoice is found to be incorrect or is otherwise not in proper form or substance, County may withhold payment for only the portion of the invoice deemed incorrect or improper. Prior to withholding payment, County shall provide Contractor with at least five (5) calendar days' written notice. Contractor shall continue providing services for up to ninety (90) calendar days after receiving notice of the invoice issue while resolution efforts are ongoing. If the invoice remains unresolved to County's satisfaction after the ninety

(90) day period, County may elect to terminate this Agreement, in accordance with the termination provisions outlined in Article 6.

If County fails to provide notice of an incorrect or improper invoice and this results in delay in reimbursement, Contractor may initiate the escalation process through County's DBH Finance Division's Invoice Review Team. This process may include escalation to the DBH Finance Division Manager and ultimately County's DBH Director or designee to ensure timely reimbursement.

If County withholds any portion of an invoice due to incorrect or improper form or substance, Contractor shall resolve the issue and communicate any delays in resolution to County's DBH Finance Division Manager within ninety (90) calendar days of receiving notice of the withholding. Failure to resolve or communicate within this timeframe may result in the withholding being deemed final and non-payable at the sole discretion of County.

Contractor shall submit all initial invoices for services rendered within a given calendar month no later than sixty (60) calendar days following the end of the month in which services are provided. Invoices submitted after this 60-day period may be rejected and not processed for payment.

If the initial invoice is submitted within the required timeframe, supplemental or revised invoices may be submitted within one hundred twenty (120) calendar days following the end of the month in which services were provided. Supplemental invoices will not be accepted if the initial invoice is not submitted timely.

All billing related to Other Health Coverage (OHC) must be submitted within one hundred twenty (120) calendar days following the month in which services were provided.

The County shall not process or pay any invoices submitted more than sixty (60) calendar days after the end of the fiscal year in which the services were performed, except for claims related to Other Health Coverage (OHC), which must be submitted within one hundred twenty (120) calendar days following the month in which services were provided.

d. Fee-For-Service Invoice Calculation

Invoices for specialty mental health services shall be calculated based on the units of time associated with each CPT or HCPCS code entered into the County billing system, multiplied by the practitioner service rates specified in Revised Exhibit C – Attachment A.

Services pending determination from Medicare, OHC, or any other third-party payers shall not be reimbursed until Explanation of Benefits (EOB) is processed and any remaining balance is transferred to Medi-Cal or other applicable coverage, in accordance with this Agreement's funding requirements.

Notwithstanding the foregoing, County may, at its sole discretion, authorize payment for services provided to individuals with OHC when such services are not fully covered by the primary payer. This discretionary payment shall only apply to the remaining balance after all applicable third-party reimbursements have been applied and upon receipt of the EOB, unless DBH expressly approves earlier payment in writing. Such approval shall be documented and remain subject to all funding requirements under this Agreement.

County payments are provisional and subject to adjustment upon completion of all cost settlement and reconciliation activities. Adjustments, including recoupments, shall be made in accordance with this Agreement. County shall provide written notice of any adjustments. Final settlement will be based on audit findings and compliance with all applicable regulations.

Revenue reporting requirements are outlined in Section VII(f) (Financial Compliance and Enforcement).

e. Cost Reimbursement Invoice Calculation

Invoices for cost reimbursement services shall be calculated based on actual expenses incurred during the applicable service month. Contractor shall submit monthly invoices in arrears, accompanied by detailed general ledgers itemizing program costs for that month. These documents shall serve as verification to ensure costs align with the approved budget in Revised Exhibit C – Attachment B.

Contractor shall maintain supporting documentation for all claimed costs and make such records available for audit by County, State, or Federal authorities upon request. Failure to submit required reports and documentation may result in County withholding payment until compliance is achieved, upon written notice.

Monthly invoices shall reflect the total amount due for allowable costs, reduced by any revenue collected from third-party payers, client-pay, or private-pay sources, and shall exclude unallowable cost such as lobbying or political contributions.

f. Corrective Action Plans

Contractor shall enter all services into the County EHR and submit invoices in accordance with the deadlines and requirements specified in this Agreement, ensuring accuracy and completeness of all information.

Failure to comply with these requirements may result in the implementation of a corrective action plan at the discretion of the County. Corrective action plans may include, but are not limited to, financial penalties or termination of this Agreement in accordance with the termination provisions outlined in Article 6.

g. Payment

County shall make payment to Contractor in arrears for services provided during the preceding month, within forty-five (45) calendar days after receipt, verification, and approval of the invoice by County.

Payments shall be made upon certification or other proof satisfactory to County that services have been performed or actual expenditures incurred in accordance with this Agreement. Any compensation not expended by Contractor pursuant to this Agreement shall automatically revert to County.

i. Incidental Expenses

Contractor shall be solely responsible for all costs and expenses not identified as reimbursable by County under this Agreement. Such costs include, but not limited to, administrative overhead, travel, and other incidental expenses.

h. Applicable Fees

Contractor shall not charge any person served or third-party payers for services provided under this Agreement unless expressly directed to do so by County at the time of referral. When directed to charge for services, Contractor shall use the uniform billing and collection guidelines prescribed by DHCS.

Contractor shall perform eligibility and financial determinations in accordance with DHCS' Uniform Method of Determining Ability to Pay (UMDAP), as outlined in BHIN 98-13 (available at dhcs.ca.gov), unless directed otherwise by County.

Contractor shall not submit claims to, or demand or collect reimbursement from, persons served or their representatives for specialty mental health or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments, as permitted under California Code of Regulations, Title 9, §1810.365(c).

Under no circumstances shall Contractor bill persons served for covered services any amount greater than would be owed if the County provided the services directly. Contractor shall comply with all applicable requirements, including 42 C.F.R. § 438.106.

i. Claiming Responsibilities for SMHS

Contractor shall enter all claims data into the County's EHR using the California Mental Health Services Authority (CalMHSA) Smart Care Procedure Codes (available at https://2023.calmhsa.org/procedure-code-definitions/) by the fifteenth (15th) calendar day of each month for services rendered in the previous month. County's EHR system will convert these codes to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding

System (HCPCS) codes, in accordance with the DHCS Billing Manual (available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx), as amended from time to time.

All claims shall be accurate, complete, and error-free, and must include all required information. Contractor is responsible for monitoring and correcting any errors within thirty (30) calendar days from the date of service to ensure timely payment. County will monitor service volume, billing amounts, and service types entered into the EHR. Any audit exceptions resulting from Contractor' reporting shall be the sole responsibility of Contractor.

Contractor shall provide all necessary data to enable County to bill Medi-Cal and meet State and Federal reporting requirements. Data may be provided through direct EHR entry, electronic file submission compatible with County systems, or system integration. Contractor shall maximize Federal Financial Participation (FFP) by claiming all eligible Medi-Cal services and correcting denied claims for resubmission.

Contractor is responsible for billing all SMHS for persons served with OHC and/or Medicare. For individuals with OHC and/or Medicare, Contractor shall bill the carrier and obtain payment or denial, or validate non-response after ninety (90) calendar days from claim submission. Contractor must report all third-party collections monthly and submit copies of EOBs or CMS 1500 forms to: DBHAccountsReceivable@fresnocountyca.gov. EOBs shall be submitted in batches by service month, with email subject lines including Contractor Name, Program Name, and Payment or Denial status.

V. Recoupments and Audits Requirements

a. Recoupment Process

County shall recapture from Contractor the value of any services or expenditures determined to be ineligible based on County or State monitoring results. County may enter into a repayment agreement with Contractor for up to twelve (12) months, with the option to extend to a total of twenty-four (24) months at County discretion. Repayment agreements require written approval by County. County may offset repayment amounts against future invoices or recoup all funds immediately. These remedies are not exclusive, and County may pursue other means of recovery.

Contractor shall be financially liable for all disallowances or audit exceptions identified through State audits, County utilization reviews, or other oversight processes. Disallowed amounts must be remitted within forty-five (45) calendar days or will be withheld from subsequent payments. Contractor shall not receive reimbursement for any services disallowed or denied by County or State review processes.

County will conduct periodic audits to verify clinical documentation, validate costs invoiced under cost reimbursement agreements, and ensure compliance with applicable regulations. Audits may require Contractor to reimburse County for previously paid services under circumstances including, but not limited to:

i. Fraud, Waste, or Abuse as defined in federal regulations.
ii. Overpayment due to errors in claiming or documentation
iii. Other reasons specified by DHCS in the SMHS Reasons for Recoupment guidance.

Contractor shall reimburse County for all overpayments identified by any oversight entity within required timeframes. Funds owed must be paid within forty-five (45) calendar days of notification or will be offset against future payments.

b. Audit Requirements

The following requirements apply to all audits and reviews conducted under this Agreement.

Contractor is responsible for ensuring the accuracy of all claims submitted, including proper documentation, coding, and compliance with SMHS standards. Contractor shall maintain confidentiality of all records in accordance with HIPAA and applicable State and Federal laws.

Contractor shall cooperate fully with County, DHCS, or other regulatory bodies in any audit or review, including providing access to records, documents, and facilities. Contractor shall allow inspection and audit for ten (10) years following the Agreement's end date or until any audit or investigation is resolved, whichever is later, pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(i)(3)(i-iii).

c. Single Audit Clause

If Contractor expends One Million Dollars ($1,000,000.00) or more in Federal or Federal flow-through funds in any fiscal year, Contractor shall conduct an annual audit in accordance with the Single Audit Standards as set forth in Office of Management and Budget (OMB) 2 CFR 200. The audit report and management letter shall be submitted to County within nine (9) months of the fiscal year end. The audit must include either a statement of findings or a statement that no findings were identified. If findings exist, Contractor shall provide a corrective action plan signed by an authorized representative and take prompt action to address any material non-compliance or weakness.

Failure to perform the required audit may result in County conducting the audit or contracting with a public accountant to perform the audit at Contractor's expense. Audit costs related to this Agreement are the sole responsibility of Contractor.

If Contractor's Federal expenditures do not meet the Single Audit Clause threshold, Contractor shall perform a program audit and submit to County within nine (9) months of the fiscal year end. The program audit must attest to Contractor's financial solvency and compliance with Agreement requirements.

Contractor shall make all records and accounts available for inspection by County, the State, the Controller General of the United States, the Federal Grantor Agency, or their authorized representatives at all reasonable times for a period of at least three (3) years following the final payment under this Agreement or until all pending matters are resolved, whichever is later.

d. Audit Requirements for Pass-Through Entities

If County determines that Contractor is a "subrecipient" or pass-through entity as defined in 2 C.F.R. § 200, Contractor shall comply with all applicable cost principles, administrative requirements, and audit standards, including those governing claims for payment or reimbursement.

Financial audit reports must include a separate schedule identifying all funds received from or passed through the County. This schedule shall specify the Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.

Contractor will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the County's DBH Director or designee. The County's Director or designee is responsible for providing the audit report to the County Auditor.

Contractor shall submit the financial audit report, including all attachments, the management letter, and any corresponding response to County within six (6) months of the end of the audit year. The County will forward the report to the County Auditor.

Any required corrective action plan must be submitted to County at the same time as the audit report or as soon thereafter as available. County shall monitor implementation of the corrective action plan as it relates to services provided under this Agreement.

VI. County-Owned Property Requirements

This section shall only apply to the program components and services provided under Cost Reimbursement. County and Contractor recognize that fixed assets are tangible and intangible property obtained or controlled under County for use in operational capacity and will benefit County for a period more than one (1) year.

a. Agreement Assets

Assets shall be tracked on an agreement-by-agreement basis. Unless otherwise permitted by the funding source, all assets shall fall under the "Equipment" category. Items of a sensitive nature, including those containing HIPAA Protected Health Information (PHI), must be purchased and allocated to a single Agreement. Examples of assets include, but are not limited to:

i. Computers (desktops and laptops);
ii. Copiers, cell phones, tablets, and other devices with any HIPAA data;
iii. Modular furniture;
iv. Land;
v. Any items over $5,000;
vi. Items of $500 or more with a lifespan of at least two (2) years (e.g., televisions, washers/dryers, printers, digital cameras, other equipment/furniture).

Contractor shall maintain an asset tracking system that includes, at a minimum:

i. Asset description and unique identifier (e.g., serial number);
ii. Acquisition date and cost;
iii. Quantity and location or assigned user;
iv. Source of grant funding (if applicable);
v. The disposition date and method (surplus, transfer, destruction, loss).

b. Retention and Maintenance

All assets shall remain County property upon expiration of this Agreement. Contractor shall participate in annual inventory and ensure return of all County-owned, undepreciated assets or reimburse County for their monetary value if unable to return them. Contractor shall:

i. Maintain equipment in good working order, normal wear and tear excepted;
ii. Label equipment with County-assigned program number and maintain inventory list as required;

Report loss or theft immediately in writing and provide a police report for stolen items.

c. Equipment Purchase

Any equipment purchased with funds under this Agreement requires prior written approval from County. Purchases must directly relate to services under this Agreement. County may deny reimbursement for unauthorized purchases.

d. Modification of Assets

Contractor must obtain prior written approval from County for any modification or change in use of property acquired or improved with Agreement funds. If such property is sold or used

for non-qualifying purposes, Contractor shall reimburse County for its current fair market value, less any portion funded by non-County sources. These requirements remain in effect for the life of the property unless relieved by State action.

VII. Additional Compliance and Reporting Requirements

Contractor acknowledges and agrees that its obligations under this Agreement are subject to all applicable local, State, and Federal laws and regulations, including but not limited to those governing Medi-Cal, HIPAA, and the False Claims Act.

a. Notification of Changes

Contractor shall provide written notice to County of any material change affecting the performance of this Agreement, including but not limited to:

i. Organizational Changes
   Changes in organizational name, Head of Service, or principal business address.

ii. Service Location Changes
   Change in any service-delivery location. Notice shall be provided at least six (6) months in advance to allow County sufficient time to comply with site certification requirements. Such notice will become part of this Agreement upon written acknowledgment by the County, provided the change of address does not conflict with any other provisions of this Agreement.

iii. Ownership, Licensure, or Capacity Changes

Any change in ownership, organizational status, licensure, or Contractor's ability to provide the quantity or quality of the contracted services. Notice shall be provided immediately and no later than fifteen (15) calendar days following the change.

Failure to provide timely notice as required herein may result in corrective action, including withholding of payment or termination of this Agreement, in accordance with the provisions outlined in Article 6.

b. Record Maintenance and Retention

Contractor shall maintain complete, accurate, and current records to demonstrate accountability for all services and fiscal activities under this Agreement. Records include, but are not limited to:

i. Service Delivery Documentation
   Monthly summary sheets, sign-in sheets, and other primary source documents supporting services provided.

ii. Fiscal Records

All financial records shall be maintained in accordance with Generally Accepted Accounting Principles (GAAP) and must account for all funds, tangible assets, revenues, and expenditures. Fiscal records shall also comply with the requirements set forth in 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

iii. Retention Requirements

Contractor shall retain all service and financial records for a minimum of ten (10) years from the date of final payment, the final date of this Agreement, final settlement, or until all audit findings are resolved, whichever is later.

iv. Access and Compliance

Contractor shall provide County access to all records upon request and comply with all applicable local, State, and Federal laws regarding the maintenance and relinquishment of medical records.

Failure to maintain records in accordance with these requirements may result in withholding of payments or termination of this Agreement, as outlined in Article 6.

c. Financial Reports

Contractor shall submit audited financial reports to County on an annual basis. The audit shall:

i. Standards

Be conducted in accordance with GAAP and generally accepted auditing standards.

ii. Submission Timeline

The audit report, including all attachments, the management letter, and any corresponding response, must be submitted to County within six (6) months of the end of the audit year.

iii. Corrective Action

If findings are identified, Contractor shall provide a corrective action plan signed by an authorized representative at the time of submission or as soon thereafter as available. County shall monitor implementation of the corrective action plan as it relates to services provided under this Agreement.

Failure to submit required financial reports within the specified timeframe may result in corrective action, including withholding of payment or termination of this Agreement, in accordance with Article 6.

d. Agreement Termination

In the event this Agreement is terminated, reaches its designated term, or Contractor ceases operations, Contractor shall:

i. Delivery of Records
Provide or make available to County all financial and service records accumulated under this Agreement, whether completed, partially completed, or in progress, within seven (7) calendar days of the termination or end date.

ii. Final Compensation
Contractor shall be entitled to payment for all SMHS satisfactorily provided through and including the effective date of termination, subject to the terms and conditions of this Agreement.
This provision shall not limit or reduce any damages owed to County resulting from Contractor's breach of this Agreement.

Failure to comply with these requirements may result in withholding payment or other remedies available to the County under Article 6.

e. Restrictions and Limitations

This Agreement is subject to all restrictions, limitations, and conditions imposed by County, State, or Federal funding sources that may affect the fiscal provisions or funding for this Agreement. Key provisions include:

i. Funding Contingency
This Agreement is contingent upon sufficient funds being made available by County, State, or Federal sources for the term of this Agreement. If the State or Federal governments reduce financial participation in the Medi-Cal program, County shall meet with Contractor to discuss renegotiating the services required.

ii. Fiscal Year Funding
Funding is allocated by fiscal year. Any unspent appropriation for a fiscal year does not roll over and is not available for services provided in subsequent years.

iii. Delayed Payments
In the event funding for these services is delayed by the State Controller, County may defer payments to Contractor. The deferred amount shall not exceed the amount of funding delayed by the State Controller to County. The deferral period shall not exceed the duration of the State Controller's delay plus forty-five (45) calendar days.

f. Financial Compliance and Enforcement

County maintains the right to monitor Contractor's performance under this Agreement to ensure accuracy of claims for reimbursement and compliance with all applicable laws and regulations.

Contractor shall claim and collect all other available revenues, including but not limited to Medicare, private insurance, grants, client rent/fees, and any other third-party funding sources. Contractor shall maintain accurate records of all such revenues collected and report them to County in the format and frequency specified by County. Reports shall be submitted concurrently with monthly invoices or as otherwise directed and must include sufficient detail to support reconciliation and verification of revenue sources.

No federal funds provided under this Agreement shall be used to pay the salary of an individual at a rate exceeding Level 1 of the Executive Schedule, as published by U.S. Office of Personnel Management and amended from time to time amended.

Federal Financial Participation shall not be available for any amount furnished to an excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or should have known of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud, pursuant to 42 U.S.C. section 1396b(i)(2).

Contractor shall be responsible for any disallowances resulting from inadequate documentation.

Failure by either party to enforce any provision of this Agreement shall not constitute a waiver of that provision or any other provision.

If Contractor fails to comply with any provision of this Agreement, County may, upon written notice, be relieved of its obligation to provide further compensation.

g. Compliance with Federal and State Laws

Contractor shall comply with all applicable Federal and State laws and regulations governing the provision of services and the use of funds under this Agreement, including but not limited to:

i. The False Claims Act employee training and policy requirements set forth in 42 U.S.C. §1396a(a)(68) and any related guidance issued by the U.S. Department of Health and Human Services;
ii. Medi-Cal program requirements;
iii. HIPAA privacy and security standards;
iv. Any other applicable statutes, regulations, and administrative rules.

Contractor shall maintain documentation demonstrating compliance with these requirements and make such documentation available to County upon request.

h. Restrictions on Fund Redirection

Contractor shall not redirect or transfer funds from one funded program to another funded program under this Agreement, except through a duly executed amendment approved by County.

Contractor shall not allocate or charge services provided to an eligible person under one funded program to another funded program unless the person served is also eligible for services under the second funded program.

i. Record Retention and Access

Contractor shall maintain complete, accurate, and current records to demonstrate accountability for all services and fiscal activities under this Agreement. Records shall include, but are not limited to:

i. Service delivery documentation (e.g., monthly summary sheets, sign-in sheets, and other primary source documents);
ii. Fiscal records maintained in accordance with Generally Accepted Accounting Principles (GAAP), accounting for all funds, tangible assets, revenues, and expenditures;
iii. Documentation required under 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Retention Requirements:

Contractor shall retain all service and financial records for a minimum of ten (10) years from the date of final payment, the final date of this Agreement, final settlement, or until all audit findings are resolved, whichever is later.

Access and Compliance:

Contractor shall provide County access to all records upon request and comply with all applicable local, State, and Federal laws regarding the maintenance and relinquishment of medical records.

Failure to maintain records in accordance with these requirements may result in withholding of payments or termination of this Agreement, as outlined in Article 6.

FEE-FOR-SERVICE RATES

**Fee-for-Service rates are established by the Department of Health Care Services. Contractor acknowledges that the rates listed in the table below are all-inclusive rates and cover all program operating expenses, including but is not limited to:

i. Direct and indirect staff time (e.g., patient care, documentation, travel, and paid time off);
ii. Total staff compensation (e.g., salaries, wages, benefits, bonuses, incentives);
iii. Vehicle expenses (e.g. gas, maintenance, insurance);
iv. Training and professional development;
v. Assets and capital equipment;
vi. Utilities overhead costs.

Indirect cost expenses shall be determined by the Contractor under the Fee-for-Service reimbursement structure.

Assigned Fee-For-Service Rate Category:
FSP ICM: FSP Rates
Outpatient: Field-Based Rates

Fee-For-Service Rate Table for Specialty Mental Health Services:

FSP	
Provider Type	**Provider Rate Per Hour**
Licensed Physician	$1,250.00
Physician's Assistant	$560.62
Nurse Practitioner	$621.59
Registered Nurse	$507.73
Certified Nurse Specialist	$621.59
Licensed Vocational Nurse	$266.72
Registered Pharmacist	$598.34
Licensed Psychiatric Technician	$228.66
Psychologist (Licensed or Waivered)	$502.71
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$325.31
Occupational Therapist	$433.04
Mental Health Rehab Specialist	$244.76
Peer Support Specialists	$256.99
Community Health Worker	$250.88
Medical Assistant	$183.35
Other Qualified Providers	$244.76
Certified AOD Counselor	$269.84

Flat Rate Type	Unit	Maximum Units That Can Be Billed	Rate
Interactive Complexity	15 min per unit	1 per allowed procedure per provider per person served	$19.48
Sign Language/Oral Interpretive Services	15 min per unit	Variable	$32.87

Field Based
(at least 50% of services are provided in the field)

Provider Type	Provider Rate Per Hour
Licensed Physician	$1,083.33
Physician's Assistant	$485.87
Nurse Practitioner	$538.71
Registered Nurse	$440.03
Certified Nurse Specialist	$538.71
Licensed Vocational Nurse	$231.16
Registered Pharmacist	$518.56
Licensed Psychiatric Technician	$198.17
Psychologist (Licensed or Waivered)	$435.68
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$281.94
Occupational Therapist	$375.30
Mental Health Rehab Specialist	$212.12
Peer Support Specialists	$222.72
Community Health Worker	$217.43
Medical Assistant	$158.91
Other Qualified Providers	$212.12
Certified AOD Counselor	$233.86

Flat Rate Type	Unit	Maximum Units That Can Be Billed	Rate
Interactive Complexity	15 min per unit	1 per allowed procedure per provider per person served	$19.48
Sign Language/Oral Interpretive Services	15 min per unit	Variable	$32.87

Clinic/Site Based (less than 50% of services are provided in the field)	
Provider Type	**Provider Rate Per Hour**
Licensed Physician	$1,000.00
Physician's Assistant	$448.49
Nurse Practitioner	$497.27
Registered Nurse	$406.18
Certified Nurse Specialist	$497.27
Licensed Vocational Nurse	$213.38
Registered Pharmacist	$478.67
Licensed Psychiatric Technician	$182.93
Psychologist (Licensed or Waivered)	$402.17
LPHA (MFT LCSW LPCC)/ Intern or Waivered LPHA (MFT LCSW LPCC)	$260.25
Occupational Therapist	$346.43
Mental Health Rehab Specialist	$195.80
Peer Support Specialists	$205.59
Community Health Worker	$200.70
Medical Assistant	$146.68
Other Qualified Providers	$195.80
Certified AOD Counselor	$215.87

Flat Rate Type	**Unit**	**Maximum Units That Can Be Billed**	**Rate**
Interactive Complexity	15 min per unit	1 per allowed procedure per provider per person served	$19.48
Sign Language/Oral Interpretive Services	15 min per unit	Variable	$32.87

Fee-For-Service Rate Table for Assisted Outpatient Treatment (AOT) and Community Assistance, Recovery, and Empowerment (CARE) Act Services:

AOT & CARE Act Administrative Activities Reimbursement Rates		
#	Activity	Activity Hourly Rate
1	Court Report Activity	$114.95
2	Court Hearing Time Activity	$91.63
3	Notice Activity	$65.40
4	Outreach and Engagement Activity	$78.68
5	Data Reporting	$97.08

Court Hearing Time: Includes activities that occur during court time such as court staffing meetings for individuals who have been petitioned through the AOT civil court process, AOT petition hearings, and any subsequent AOT hearings; initial hearings, hearings on the merits, case management hearings, CARE agreement process meetings, clinical evaluation review hearings, CARE plan review hearings, regular status update hearings, one-year status hearings, evidentiary hearings, graduation hearings, reappointment to CARE hearings, and hearings that can occur at any time during the AOT or CARE process to address a change of circumstances.

Court Report: Includes drafting AOT petitions, affidavits, and reports; reports such as prima facie county reports, CARE agreement reports, clinical evaluation reports, CARE plan reports, supplemental reports, regular status update reports for CARE Act scheduled hearings, one-year status reports, graduation plan reports, and reappointment to CARE reports.

Outreach and Engagement: Includes all AOT assertive outreach and engagement activities required to determine eligibility and encourage voluntary participation in services; all CARE outreach and engagement activities required pursuant to W&I Code, sections 5977(a)(5)(A) and 5977(c)(2) to engage the respondent in voluntary services, to develop a CARE agreement with the respondent, and outreach done to engage the respondent in jointly preparing a graduation plan pursuant to W&I Code, section 5977.3(a)(3).

Notice: Includes drafting notices that may include but are not limited to, AOT hearing on the petition notices, subsequent hearing notices, hearing on the issue of noncompliance with the agreement notices, and 60 day review hearing notices; prima facie respondent county notices, 30 additional days to engage respondent notices, initial appearance notices, investigation report notices, hearing on the merits notices, case management hearing notices, CARE agreement progress meeting notices, clinical evaluation review hearing notices, CARE plan review hearing notices, regular status update report (every 60 days) notices, one-year status hearing (month 11) notices, evidentiary hearing notices, graduation hearing notices, and reappointment to CARE notices.

Data Reporting: Includes providing AOT specified data to be reported to DHCS annually pursuant to W&I Code, section 5348(d), including but not limited to, number of persons served by the program, contacts with law enforcement, days of hospitalization, adherence to prescribed treatment, victimization, violent behavior, substance abuse, and other data as determined by the department and other stakeholders as outlined in the DHCS AOT Data Dictionary; collecting and reporting data measures outlined in BHIN 23-052, including but not limited to, demographics of participants, housing placements, continuation of treatment information, and other data as determined by the department and other stakeholders.

Adult FSP - DART West
Mental Health Systems, Inc. dba Turn Behavioral Health Services
FSP ICM FFS Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.
For each Specialty Mental Health Services FY, please provide your proposed maximum compensation based upon estimated services provided within the corresponding blue cells.
For each Whatever it Takes Fund FY, please provide your estimated annual persons served within the corresponding blue cells.

Specialty Mental Health Services		
Maximum Compensation FY 26-27	$	4,200,000
Maximum Compensation FY 27-28	$	5,410,000
Maximum Compensation FY 28-29	$	6,684,000
Maximum Compensation FY 29-30	$	7,462,000

Specialty Mental Health Services Maximum Compensation	$	23,756,000

Adult FSP - DART West
Mental Health Systems, Inc. dba Turn Behavioral Health Services
Whatever It Takes Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.

Whatever it Takes Fund		
Maximum Compensation FY 26-27	**$**	**200,000**
Maximum Compensation FY 27-28	**$**	**250,000**
Maximum Compensation FY 28-29	**$**	**300,000**
Maximum Compensation FY 29-30	**$**	**325,000**

Whatever It Takes Maximum Compensation	**$**	**1,075,000**

1000: Whatever It Takes	
Acct #	**Line Item Description**
1001	Child Care
1002	Client Housing Support
1003	Client Transportation & Support
1004	Clothing, Food, & Hygiene
1005	Education Support
1006	Employment Support
1007	Household Items for Clients
1008	Medication Supports
1009	Program Supplies - Medical
1010	Utility Vouchers
1011	Other (specify)

Adult FSP - DART West
Mental Health Systems, Inc. dba Turn Behavioral Health Services
Outpatient FFS Maximum Compensation

Instructions:
At the top, please provide the name of the program and your organization's name.
For each Specialty Mental Health Services FY, please provide your proposed maximum compensation based upon estimated services provided within the corresponding blue cells.

Specialty Mental Health Services		
Maximum Compensation FY 26-27	$	190,921
Maximum Compensation FY 27-28	$	196,482
Maximum Compensation FY 28-29	$	202,043
Maximum Compensation FY 29-30	$	207,604

Specialty Mental Health Services Maximum Compensation	$	797,050

CARE Act- DART West
Mental Health Systems, Inc. dba Turn Behavioral Health Services
CARE Act Incentives Maximum Compensation

CARE Act incentive funding may be used to provide food, meals, clothing, hygiene products, gift cards, or other basic-need goods to address immediate needs, build rapport, and encourage respondent (person served) engagement. Expenditures are limited to a maximum of $20 per instance for food, meals, or coffee, and up to $30 for clothing and hygiene items. Gift cards may not exceed $20 and shall not be issued for businesses that sell tobacco or alcohol. All incentive items, including gift cards must be accounted for in a tracking log that will include, at a minimum: 1) Date distributed, 2) Name & signature of staff releasing the incentive/gift card, 3) Initials of respondent, 4) Description of incentive, 5) Amount (dollar value) of incentive, 6) Name & signature of program manager verifying the information, & 7) Date of verification. Supporting documentation, such as receipts for the purchase of all incentives must be retained and will be subject to verification by DBH on a monthly basis.

Incentives Fund	Average Caseload	Rate per month	
Maximum Compensation FY 25-26	50	$80	$ 4,000.00
Maximum Compensation FY 26-27	50	$80	$ 48,000.00
Maximum Compensation FY 27-28	50	$80	$ 48,000.00
Maximum Compensation FY 28-29	50	$80	$ 48,000.00
Maximum Compensation FY 29-30	50	$80	$ 48,000.00

Program Maximum Compensation	$ 196,000