COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

THIS AGREEMENT ("Agreement") is entered into as of September 20, 2024, between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and **BH-TC Opco, LLC, dba Jackson House Tulare,** ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

A. COUNTY wishes to retain services of the CONTRACTOR for the provision of voluntary short-term, crisis residential treatment services.

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

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

THE PARTIES AGREE AS FOLLOWS:

1. TERM: This Agreement becomes effective as of July 1, 2024, and expires at 11:59 PM on June 30, 2025, unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement.

2. SERVICES: CONTRACTOR shall provide COUNTY with the services shown on the attached **Exhibits A, A-1, and A-2.**

3. PAYMENT FOR SERVICES: As consideration for the services provided by CONTRACTOR hereunder, COUNTY shall pay CONTRACTOR in accordance with the attached **Exhibits B and B-1.**

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

5. GENERAL AGREEMENT TERMS AND CONDITIONS: COUNTY'S "General Agreement Terms and Conditions (Form revision approved as of 01/01/2021)" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

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

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

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

COUNTY:

TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY
ATT: CONTRACTS UNIT
5957 South Mooney Blvd
Visalia, CA 93277
Phone No: 559-624-8000

With a Copy to:

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

CONTRACTOR:
BH-TC Opco, LLC, dba Jackson House Tulare
7050 Parkway Drive
La Mesa, CA 91942
Phone No,.: 619-889-3399

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

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

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9. COUNTERPARTS: The Parties may sign this Agreement in counterparts, each of which shall be deemed an original and all of which taken together form one and the same agreement. A signed copy or signed counterpart of this Agreement delivered by facsimile, email, or other means of electronic transmission shall be deemed to have the same legal effect as delivery of a signed original or signed copy of this Agreement.

10. MANUAL OR ELECTRONIC SIGNATURES: The Parties may sign this Agreement by means of manual or electronic signatures. The Parties agree that the electronic signature of a Party, whether digital or encrypted, is intended to authenticate this Agreement and to have the same force and effect as a manual signature. For purposes of this Agreement, the term "electronic signature" means any electronic sound, symbol, or process attached to or logically associated with this Agreement and executed and adopted by a Party with the intent to sign this Agreement, including facsimile, portable document format, or email electronic signatures, pursuant to the California Uniform Electronic Transactions Act (Cal. Civ. Code §§ 1633.1 to 1633.17), as it may be amended from time to time.

[THIS SPACE LEFT BLANK INTENTIONALLY; SIGNATURES FOLLOW ON NEXT PAGE]

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

BH-TC OPCO, LLC, DBA JACKSON HOUSE TULARE

Date: 8/6/2024

By DocuSigned by: BDC47BDCB60F494...
Print Name Bruce Figuered
Title CEO

Date: 8/13/2024

By DocuSigned by: A147E1574E584E8...
Print Name Chad Engbrecht
Title CFO

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

COUNTY OF TULARE

Date: 9/10/2024

By
Chair, Board of Supervisors

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

By
Deputy Clerk

Approved as to Form
COUNTY COUNSEL

By David J. Gomez
Deputy
Date: 08/13/2024

Matter # 20241008

EXHIBIT A
SCOPE OF SERVICES
BH-TC OPCO, LLC, DBA JACKSON HOUSE TULARE
FISCAL YEAR 2024/2025

Jackson House Tulare (CONTRACTOR) is a voluntary short-term 16-bed crisis residential treatment services (CRTS) facility located at 1168 Leland Avenue Tulare, California 93274. Crisis residential programs are non-medical facilities that provide therapeutic and/or rehabilitation services in a residential home-like setting. These services are an alternative to hospitalization for clients experiencing an acute psychiatric episode or crisis requiring temporary removal from their home environment. The CRTS facility is licensed as a Social Rehabilitation program by the California Department of Social Services, and it is in operation 24-hours per day, seven (7) days per week. The primary focus of the crisis residential program is to stabilize psychiatric or behavioral symptoms, evaluate treatment needs, and to develop and implement individualized treatment plans with the goal of keeping patients out of emergency rooms or inpatient acute care facilities.

1. SERVICES PROVIDED

1.1 CONTRACTOR shall provide a range of activities and services that support the beneficiaries in their effort to restore, maintain and apply interpersonal and independent living skills and access community support systems. In an effort to reduce crisis risk and to meet the clinical needs of beneficiaries, CONTRACTOR shall ensure that sufficient and timely services are provided based on elements of multiple research and evidence-based practices that will be tailored to the CRTS program. Services will include, but are not limited to, the following: Medication Support, Peer support, (Situation, Task, Action, and Result (STAR) Behavioral Interview Model, Cognitive Behavioral Therapy (CBT), Dialectical behavior therapy (DBT), Health Realization, Motivational Interviewing, Wellness Recovery Action Plans (WRAP), Acceptance and Commitment Therapy, (ACT), Illness Recovery Management, evidence-based prescribing practices, Consumer-centered therapy, Harm Reduction, Behavioral therapy, Self-Management And Recovery Training (SMART recovery) and 12-step facilitation, family education and support services. CONTRACTOR will also provide linkage to other community services, activities of daily living, consumer safety, budgeting, education for healthy living and social skills.

1.2 CONTRACTOR agrees to perform the services as described in Section 1.1 of this exhibit, and related reporting responsibilities in compliance with Tulare County Health and Human Services Agency's, Behavioral Health Branch (COUNTY) contract obligations.

1.3 If CONTRACTOR fails to perform the services as described in Section 1.1 of this exhibit, and fails to meet their reporting responsibilities satisfactorily, the COUNTY will issue a plan of correction to address identified areas of non-compliance. Failure to cooperate or implement and sustain sufficient corrective action as indicated may result in withholding of payment or termination of this Agreement.

2. SERVICE DELIVERY SITE AND AVAILABILITY

2.1 CONTRACTOR shall ensure CRTS have a clearly established certified site, although all services need not be delivered at that site. As much as staff safety permits and in accordance with Title 9 of the California Code of Regulations, the CONTRACTOR may also offer services in the community.

3. TARGET GROUP TO BE SERVED

3.1 To qualify for admission into a Residential Treatment program, an individual must demonstrate a need for crisis stabilization due to a mental health disorder, but not meet the criteria for acute hospitalization. Additionally, the individual's mental state must substantially interfere with their ability to maintain stable adjustment or independent functioning within the community. Individuals to be served under this Agreement shall also meet the Admission Criteria outlined in this Agreement.

ADMISSION CRITERIA:

3.1.1 Adult men and women ages 18 and older.

3.1.2 Diagnosis of a mental illness in accordance with the current version of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, or Diagnosis of a mental illness with co-occurring substance abuse issues.

3.1.3 Intellectual capacity to effectively participate and benefit from the treatment program.

3.1.4 Currently in a crisis requiring residential treatment level of care.

3.1.5 Medically appropriate.

3.1.6 Voluntary Status

3.1.7 Individuals that meet the Exclusionary Criteria under this Agreement will not be served.

EXCLUSIONARY CRITERIA:

3.2.1 Imminently suicidal or homicidal behavior or who present serious risk including any one of the following:

a. Overdose with medical complications but no medical clearance.

b. Suicidal attempt with medical complications but no medical clearance.

c. Demonstrates high-risk behaviors to harm self or others.

d. Recent homicidal behavior that has caused physical injury.

3.2.2 Psychotic symptomatology including any one of the following:

a. Psychotic behavior associated with severe neurological deficits.

b. Psychotic symptomatology that causes inability to perform basic self-care needs.

c. Aggressive acting out of delusional or hallucinatory material.

d. Severe developmental communication disorder that compromises treatment.

e. Severe social withdrawal that compromises physical well-being.

3.2.3 Individuals who are manifesting a physical illness requiring close medical supervision.

3.2.4 Individuals who have the ability to function in a less restrictive environment.

3.2.5 Individuals who are not able to perform self-care needs with minimal supervision.

3.2.6 Individuals with a medical complication that prohibits them from focusing on mental health.

3.2.7 Individuals with a prohibited health condition (Naso-gastric and naso-duodenal tubes; active, communicable Tuberculosis (TB); conditions that require 24-hour nursing care and/or monitoring; Stage 3 and 4 dermal ulcers; any other condition or care requirements which would require the facility to be licensed as a health facility as defined by Sections 1202 and

1250 of the Health and Safety Code).

3.2.8 Individuals with a restricted health condition, only if deemed that it cannot be properly cared for in-house (Use of inhalation-assistive devices; Colostomy/ileostomies; Requirement for fecal impaction removal, enemas, suppositories; Use of catheters; Staph or other serious, communicable infections; Insulin-dependent Diabetes; Stage 1 and 2 dermal ulcers; Wounds; Gastrostomies; Tracheostomies).

3.2.9 Individuals under 18 years old.

3.3 CONTRACTOR agrees to admit patients referred by COUNTY who meet established Admission Criteria.

4. LENGTH OF STAY

4.1 The planned length of stay for individuals admitted into the program shall be in accordance with the individual's assessed needs, but not to exceed 30 days, unless circumstance require a longer length of stay to ensure successful completion of the treatment plan and appropriate referral. The reason for a length of stay beyond 30 days would require COUNTY approval.

5. AUTHORIZATION

5.1 All services provided under this Agreement shall be authorized by the COUNTY as defined in the County Mental Health Plan (MHP) Policy and Procedures. Services are limited to Tulare County Medi-Cal beneficiaries and individuals authorized as specified in the County Policy and Procedures.

5.2 Crisis residential services require concurrent review and authorization by the County MHP . For beneficiaries referred to crisis residential services, the referral will serve as the initial authorization request as specified in the County Policy and Procedure.

5.3 The CONTRACTOR must notify the MHP of any approved or denied admission within 24 hours by submitting a copy of the completed screening tool or assessment and any other supporting documentation at the time of admission.

Initial requests for authorization of crisis residential services not initiated by the MHP should be submitted to the Mental Health Managed Care Unit email (QIManagedCare@Tularecounty.ca.gov) within 24 hours of admission via the CRTS Authorization Review Form. Assessment and progress notes should be included when they have not already been entered into Tulare County's Electronic Health Record system.

5.4 Should the beneficiary require a longer stay than what was initially authorized, the services must be reauthorized concurrently with the beneficiary's stay and based on documentation of the beneficiary's continued need for services. Requests for continued stay should be submitted to the MHP's Managed Care Unit email (QIManagedCare@Tularecounty.ca.gov) with the CRTS Authorization Review Form. Assessment and progress notes should be included when they have not already been entered into Tulare County's Electronic Health Record system.

5.5 The MHP may elect to authorize multiple days, based on the beneficiary's behavioral health needs, for as long as the crisis residential treatment services are medically necessary. The initial authorization request is valid for 14 days and extensions must be authorized every seven (7) days thereafter not to exceed a total of 30 days, unless circumstances require a longer length of stay for crisis stabilization. Clinical justification for admission and re-authorization requests to receive crisis residential treatment must be sufficiently documented in the client's case record. Under no circumstances may the length of stay exceed 89 days. Decisions for authorization and re-authorization of crisis residential services will be made by a Licensed Practitioner of Healing Arts (LPHA) of the MHP.

6. ADMISSION POLICIES

6.1 CONTRACTOR shall ensure compliance with Section 532.3; Title 9 California Code of Regulations (Admission/discharge criteria) as follows:

6.1.1 The program shall have Admission and Discharge criteria policies in writing and shall be consistent with program goals.

6.1.2 The program shall have written policies and procedures for orienting new clients to the services.

6.1.3 The range of services provided shall be discussed with the prospective client or an authorized representative prior to admission so that the program's services are clearly understood.

7. STAFFING

7.1 CONTRACTOR certifies that all personnel are qualified and hold appropriate licenses in accordance with Welfare and Institutions Code Sections 5600.2 and all other applicable requirements of the law, including Title 9, CCR Section 622-630 as identified in the County MHP Policy and Procedures. During the term of this Agreement, CONTRACTOR shall have available and provide upon request to authorized representatives of COUNTY a list of individuals who are providing services hereunder detailing their title, professional degree, and experience. Credentialing or proof of credentialing will be required from the CONTRACTOR for all clinicians of an Organizational Provider and a copy of each clinician's credentialing shall be sent to COUNTY. The number and classification of personnel at CONTRACTOR'S site of service shall reflect the understanding reached during the negotiation of this Agreement and reasonable workload standards, detailed in Exhibit A-2, Personnel Report.

7.2 CONTRACTOR will confirm that CONTRACTORS' licenses have not expired and there are no current limitations on the CONTRACTORS' licenses. CONTRACTOR will verify the licensure status of its providers and report findings to COUNTY on a monthly basis.

7.3 CONTRACTOR certifies that any employee who will be performing any of the duties and obligations of CONTRACTOR have the experience and training necessary to perform such tasks.

7.4 CONTRACTOR shall ensure scheduling of staff is in accordance with Health Care State Regulations – California Code of Regulations, Title 9, Section 531, which provides for at least two (2) full time members to be on duty 24 hours a day, seven (7) days per week.

8. BREACH DISCOVERY AND NOTIFICATION

8.1 Following the discovery of a Breach of Unsecured Protected Health Information

(PHI), CONTRACTOR shall notify COUNTY of such Breach, however both Parties agree to a delay in the notification if so, advised by a law enforcement official pursuant to 45 CFR § 164.412.

8.1.1 A Breach shall be treated as discovered by CONTRACTOR as of the first day on which such Breach is known to CONTRACTOR or, by exercising reasonable diligence, would have been known to CONTRACTOR.

8.1.2 CONTRACTOR shall be deemed to have knowledge of a Breach, if the Breach is known, or by exercising reasonable diligence would have known, to any individual who is an employee, officer, or other agent of CONTRACTOR, as determined by federal common law of agency.

8.2 CONTRACTOR shall provide the notification of the Breach immediately to the COUNTY Compliance Officer at:

Compliance and Ethic Department
Email: ComplianceOfficer@tularecounty.ca.gov
Hotline: (855) 513-8896
Fax: (559)713-3730
Mail: Compliance Officer
5957 S Mooney Blvd
Visalia, CA 93277

CONTRACTOR'S notification may be oral but shall be followed by written notification within 24 hours of the oral notification.

8.2.1 CONTRACTOR'S notification shall include, to the extent possible:

a. The identification of each individual whose Unsecured PHI has been, or is reasonably believed by CONTRACTOR to have been, accessed, acquired, used, or disclosed during the breach.

b. Any other information that COUNTY is required to include in the notification to Individual under 45 CFR §164.404(c) at the time CONTRACTOR is required to notify COUNTY or promptly thereafter as this information becomes available, even after the regulatory sixty (60) day period set forth in 45 CFR § 164.410 (b) has elapsed, including:

- A brief description of what happened, including the date of

the Breach and the date of the discovery of the Breach, if known.

- A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved).
- Any steps individuals should take to protect themselves from potential harm resulting from the Breach.
- A brief description of what CONTRACTOR is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any future Breaches; and
- Contact procedures for individuals to ask questions or learn additional information.

8.2.2 COUNTY may require CONTRACTOR to provide notices to the individual as required in 45 CFR § 164.404, if it is reasonable to do so under the circumstances, at the sole discretion of the COUNTY.

8.2.3 In the event that CONTRACTOR is responsible for a Breach of Unsecured PHI in violation of the Health Insurance Portability and Accountability ACT (HIPAA) Privacy Rule, CONTRACTOR shall have the burden of demonstrating that CONTRACTOR made all notifications to COUNTY consistent with this Paragraph b) and as required by the Breach notification regulations, or in the alternative, that the acquisition, access, use, or disclosure of PHI did not constitute a Breach.

8.2.4 CONTRACTOR shall maintain documentation of all required notifications of a Breach or its risk assessment under 45 CFR § 164.402 to demonstrate that a breach did not occur.

8.2.5 CONTRACTOR shall provide the COUNTY with all specific and pertinent information about the Breach. Including the information listed in Section 8.c.(2)(1)-(5) above, if not yet provided, to permit COUNTY to meet its notification obligations under Subpart D of 45 CFR Part 164 as soon as

practicable, but in no event later than fifteen (15) calendar days after CONTRACTOR'S initial report of the Breach to COUNTY pursuant to Subparagraph 8.b. above.

8.2.6 CONTRACTOR shall continue to provide all additional pertinent information about the Breach to COUNTY as it may become available, in reporting increments of five (5) business days after the last report to COUNTY. CONTRACTOR shall also respond in good faith to any reasonable requests for further information or follow-up information after reporting to COUNTY when such a request is made by the COUNTY.

8.2.7 CONTRACTOR shall bear all expenses or other costs associated with the Breach and shall reimburse COUNTY for all expenses COUNTY incurs in addressing the Breach and consequences thereof, including costs of investigation, notification, remediation, documentation, or other costs associated with addressing the Breach.

9. MEETINGS

9.1 CONTRACTOR and COUNTY shall meet on a quarterly basis to discuss CONTRACTOR'S performance under this Agreement, including, but not limited to, documentation, billing, quality of care, coordination of services, Patients' Rights, disputes, and exchange of information. Meetings shall be coordinated by the COUNTY'S designee.

10. PROGRAM MONITORING

10.1 COUNTY shall monitor the services provided by CONTRACTOR as stipulated in the Agreement and County MHP Policy and Procedures. The monitoring will include all clinical, fiscal, and administrative components, including compliance with COUNTY'S "Practice Guidelines." Program monitoring conducted by COUNTY will also consist of site visits to be performed at CONTRACTOR'S site(s) of operation to verify that all clinical, fiscal, and administrative components, as appropriate, are in compliance with the requirements set forth in federal and state regulation, the County Policy and Procedures, and the Agreement between COUNTY and CONTRACTOR. COUNTY shall conduct a minimum of one site visit per fiscal year.

10.2 COUNTY will monitor CONTRACTOR'S compliance with the provisions of this Agreement and the COUNTY'S contract with California Department of Health Care

Services (DHCS). COUNTY will issue to CONTRACTOR a corrective action plan if deficiencies are identified.

11. CONTRACTOR SCREENINGS

11.1 CONTRACTOR shall verify that all of its providers are not included on the following:

11.1.1 Office of Inspector General List of Excluded Individuals/Entities (LEIE);

11.1.2 DHCS Medi-Cal List of Suspended of Ineligible Providers;

11.1.3 Social Security Administration's Death Master File; and,

11.1.4 Excluded Parties List System/System Award Management (EPLS/SAM) database.

11.2 CONTRACTOR will verify and confirm to the MHP on a monthly basis that none of its providers are included on the LEIE, DHCS Medi-Cal List of Suspended or Ineligible Providers, or the EPLS/SAM database. CONTRACTOR will verify and confirm to COUNTY that, prior to hiring, its providers are not included on the Social Security Administration's Death Master File. CONTRACTOR will notify COUNTY within one business day should any of its providers appear on the LEIE, DHCS Medi-Cal List of Suspended or Ineligible Providers, Social Security Administration's Death Master File, or the EPLS/SAM database.

12. ANNUAL TRAINING

12.1 CONTRACTOR shall ensure all employees and volunteers complete annual training in the areas of HIPAA, Privacy, and Security Awareness; Compliance; and Cultural Competence. CONTRACTOR shall provide record of employee and volunteer training attendance to COUNTY.

12.2 COUNTY will prescribe annual HIPAA, Privacy and Security Awareness; Compliance; and Cultural Competence training and additional training as required in the Health and Huaman Services Agency Behavioral Health Branch Training Plan.

13. QUALITY IMPROVEMENT

13.1 The Quality Management Unit will review documentation to ensure compliance with regulations as specified in the County Policy and Procedures.

14. COMMUNICATIONS

14.1 Any questions related to documentation, billing, and the content of this Agreement and the requirements set forth herein may be directed to the following:

Dr. Natalie S. Bolin

MHContracts@tularecounty.ca.gov

15. COMPLIANCE WITH NEW REGULATIONS / COUNTY BULLETINS

15.1 CONTRACTOR agrees to comply with any new or updated regulations issued by DHCS or by COUNTY via COUNTY Bulletins and Policy and Procedures during the term of this Agreement.

16. ADVANCE DIRECTIVES

16.1 CONTRACTOR agrees to comply with COUNTY'S policies and procedures on advance directives.

17. REPORTING UNUSUAL OCCURRENCES

17.1 CONTRACTOR must report unusual occurrences to COUNTY. An unusual occurrence is any event which threatens the welfare, safety, or health of any client, employee, or visitor. The types of unusual occurrences that fall under this definition include, but are not limited to:

17.1.1 Death including suicide, homicide, natural cause death, accidental death.

17.1.2 Any of the following with serious outcome:

- **a.** Suicide attempt
- **b.** Physical assault
- **c.** Patient escape
- **d.** Seclusion/restraint
- **e.** Natural disaster
- **f.** Major accident/event resulting in major/grave physical injury(s) requiring medical attention

17.1.3 Any of the following with or without serious outcome:

- **a.** Serious criminal activity involving clients and/or staff
- **b.** Sexual acts/assault/rape
- **c.** Patient neglect/abuse
- **d.** Major epidemic
- **e.** Fires/explosions/poisoning

17.2 CONTRACTOR is required to notify the COUNTY Quality Assurance/Compliance Unit by email within 24 hours if any of the above incidents occur by emailing CONTRACTOR Relations staff at QIManagedCare@tularecounty.ca.gov.

17.2.1 Reports are to include the following elements:

a. Complete written description of event including outcome
b. Written report of CONTRACTOR'S investigation and conclusions
c. List of individuals directly involved and/or direct knowledge of event

17.3 COUNTY will investigate the incident and, depending on the nature and seriousness of the incident, may refer the investigation to the appropriate licensing agency. After the review of the incident, the COUNTY Quality Assurance/Compliance staff may mandate a corrective action plan.

18. OTHER CONTRACTOR RESPONSIBLITIES

18.1 CONTRACTOR will comply with Code of Federal Regulations (42 C.F.R. § 455.434(a) which requires that providers who are enrolled in the State of California Medi-Cal/Medicaid program, including subcontracted providers are required to consent to criminal background checks including fingerprinting when required to do so by the California Department of Healthcare Services or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider

EXHIBIT A-1
TULARE COUNTY MENTAL HEALTH PLAN
QUALITY MANAGEMENT STANDARDS

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

Section 1. SERVICES AND ACCESS PROVISIONS

1. CERTIFICATION OF ELIGIBILITY

   CONTRACTOR will, in cooperation with COUNTY, comply with Section 14705.5 of California Welfare and Institutions Code to obtain a certification of a client's eligibility for SMHS under Medi-Cal.

2. ACCESS TO SPECIALTY MENTAL HEALTH SERVICES

   A. In collaboration with the COUNTY, CONTRACTOR will work to ensure that individuals to whom the CONTRACTOR provides SMHS meet access criteria, as per California Department of Health Care Services (DHCS) guidance specified. Specifically, the CONTRACTOR will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below.

   B. For enrolled clients 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 clients who meet either of the following criteria, (I) or (II) below. If a client under age 21 meets the criteria as described in (I) below, the client meets criteria to access SMHS; it is not necessary to establish that the client also meets the criteria in (II) below.

      I. The client 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.

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

1) 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).

2) A suspected mental health disorder that has not yet been diagnosed.

3) Significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

C. For clients 21 years of age or older, CONTRACTOR shall provide covered SMHS for clients who meet both of the following criteria, (I) and (II) below:

I. The client has one or both of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities

b. A reasonable probability of significant deterioration in an important area of life functioning

II. The client's condition as described in paragraph (I) 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

3. ADDITIONAL CLARIFICATIONS

A. Criteria

I. 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 client had a co-occurring substance use disorder

B. Diagnosis Not a Prerequisite

I. 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.

4. MEDICAL NECESSITY

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

B. 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.

C. 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.

5. COORDINATION OF CARE

A. CONTRACTOR shall ensure that all care, treatment and services provided pursuant to this Agreement are coordinated among all providers who are serving the client, 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 client-centered and whole-person approach to services.

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

C. CONTRACTOR shall include in care coordination activities efforts to connect, refer and link clients 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.

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

E. To facilitate care coordination, CONTRACTOR will request a HIPAA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state and federal privacy laws and regulations.

6. CO-OCCURRING TREATMENT AND NO WRONG DOOR

A. Specialty and Non-Specialty Mental Health Services can be provided concurrently, if those services are clinically appropriate, coordinated, and not duplicative. When a client meets criteria for both NSMHS and SMHS, the client should receive services based on individual clinical need and established therapeutic relationships. Clinically appropriate and covered SMHS can also be provided when the client has a co-occurring mental health condition and substance use disorder.

B. Under this Agreement, CONTRACTOR will ensure that clients receive timely mental health services without delay. Services are reimbursable to CONTRACTOR by COUNTY even when:

I. 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 client does not meet criteria for SMHS.

II. If CONTRACTOR is serving a client receiving both SMHS and NSMHS, CONTRACTOR holds responsibility for documenting coordination of care and ensuring that services are non-duplicative.

Section 2. AUTHORIZATION AND DOCUMENTATION PROVISIONS

1. SERVICE AUTHORIZATION

A. CONTRACTOR will collaborate with COUNTY to complete authorization requests in line with COUNTY and DHCS policy.

B. 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.

C. CONTRACTOR shall respond to COUNTY in a timely manner when consultation is necessary for COUNTY to make appropriate authorization determinations requests in line with COUNTY and DHCS policy.

D. 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.

E. CONTRACTOR shall alert COUNTY when an expedited authorization decision (no later than 72 hours) is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function.

2. DOCUMENTATION REQUIREMENTS

A. CONTRACTOR will follow all documentation requirements as specified in Section 2.2-2.8 inclusive in compliance with federal, state and COUNTY requirements.

B. 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 must be identified as provided in-person, by telephone, or by telehealth.

C. All services shall be documented utilizing COUNTY-approved templates and contain all required elements. CONTRACTOR agrees to satisfy the chart documentation requirements and the contract between COUNTY and DHCS. Failure to comply with documentation standards specified in this Article require corrective action plans.

3. ASSESSMENT

A. CONTRACTOR shall ensure that all client medical records include an assessment of each client's need for mental health services.

B. 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 client's medical record.

C. For clients aged six (6) through 20, the Child and Adolescent Needs and Strengths (CANS), and for clients age three (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.

D. 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.

4. ICD-10

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

B. 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.

C. 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.

5. PROBLEM LIST

A. CONTRACTOR will create and maintain a Problem List for each client 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.

B. CONTRACTOR must 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.

C. 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.

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

E. 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 client, in accordance with generally accepted standards of practice.

6. TREATMENT AND CARE PLANS

A. CONTRACTOR is not required to complete treatment or care plans for clients under this Agreement, except in the circumstances specified in current guidance from DHCS and that may follow after execution of this Agreement.

7. PROGRESS NOTES

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

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

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

D. 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.

E. 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.

8. TRANSITION OF CARE TOOL

A. CONTRACTOR shall use a Transition of Care Tool for any clients 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, in order to ensure continuity of care.

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

9. TELEHEALTH

A. 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.

B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.

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

D. Medical records for clients served by CONTRACTOR under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by CONTRACTOR. Such consent must be obtained at least once prior to initiating applicable health care services.

E. COUNTY may at any time audit CONTRACTOR'S telehealth practices, and CONTRACTOR must allow access to all materials needed to adequately monitor CONTRACTOR'S adherence to telehealth standards and requirements.

Section 3. CHART AUDITING AND REASONS FOR RECOUPMENT

1. MAINTENANCE OF RECORDS

A. CONTRACTOR shall maintain proper clinical and fiscal records relating to clients served under the terms of this Agreement, as required by the Director, DHCS, and all applicable state and federal statutes and regulations. Client records shall include but not be limited to admission records, diagnostic studies and evaluations, client interviews and progress notes, and records of services provided. All such records shall be maintained in sufficient detail to permit evaluation of the services provided and to meet claiming requirements.

2. ACCESS TO RECORDS

A. 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, 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.

3. FEDERAL, STATE AND COUNTY AUDITS

A. In accordance with the California Code of Regulations, Title 9, Chapter 11, Section 1810.380(a), COUNTY will conduct monitoring and oversight activities to review CONTRACTOR'S SMHS programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to SMHS as established in BHIN 21-073, in compliance with

the applicable state and federal laws and regulations, and/or the terms of the Agreement between CONTRACTOR and COUNTY, and future BHINs which may spell out other specific requirements.

4. INTERNAL AUDITING

   A. CONTRACTORS of sufficient size as determined by COUNTY shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet SMHS definitions and be documented accurately.

   B. 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 in a timely manner.

5. CONFIDENTIALITY IN AUDIT PROCESS

   A. CONTRACTOR and COUNTY mutually agree to maintain the confidentiality of CONTRACTOR'S client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA and California Welfare and Institutions Code, Section 5328. CONTRACTOR shall inform all of its officers, employees, and agents of the confidentiality provisions of all applicable statutes.

   B. CONTRACTOR'S fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.

   C. CONTRACTOR'S records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the COUNTY. All statistical data or information requested by the Director shall be provided by the CONTRACTOR in a complete and timely manner.

6. REASONS FOR RECOUPMENT

   A. COUNTY will conduct periodic audits of CONTRACTOR files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and COUNTY regulations.

   B. Such audits may result in requirements for CONTRACTOR to reimburse COUNTY for services previously paid in the following circumstances:

      I. Identification of Fraud, Waste or Abuse as defined in federal regulation

         a. Fraud and abuse are defined in C.F.R. Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d).

         b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulation-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

      II. Overpayment of CONTRACTOR by COUNTY due to errors in claiming or documentation.

      III. Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.

   C. CONTRACTOR shall reimburse COUNTY for all overpayments identified by CONTRACTOR, COUNTY, and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

7. COOPERATION WITH AUDITS

   A. CONTRACTOR shall cooperate with COUNTY in any review and/or audit initiated by COUNTY, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite programs, fiscal, or chart reviews and/or audits.

   B. In addition, CONTRACTOR shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.

   C. CONTRACTOR shall notify the COUNTY of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. COUNTY shall reserve the right to attend any or all parts of external review processes.

   D. CONTRACTOR shall allow inspection, evaluation and audit of its records, documents and facilities for ten years from the term end date of this Agreement or in the event CONTRACTOR has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R.§§ 438.3(h) and 438.230I(3)(i-iii).

Section 4. CLIENT PROTECTIONS

1. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

   A. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by CONTRACTOR must be immediately forwarded to the COUNTY'S Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.

   B. CONTRACTOR shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.

   C. Aligned with MH SUDS IN 18-010E and 42 C.F.R. §438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by CONTRACTOR within the specified timeframes using the template provided by the COUNTY.

   D. NOABDs must be issued to clients 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 must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the COUNTY. The CONTRACTOR must inform the COUNTY immediately after issuing a NOABD.

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

   F. CONTRACTOR must provide clients any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.

   G. CONTRACTOR must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the COUNTY and available upon request to DHCS.

2. ADVANCED DIRECTIVE

   A. CONTRACTOR must 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).

3. CONTINUITY OF CARE

   A. 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).)

Section 5. PROGRAM INTEGRITY

1. GENERAL

   A. As a condition of receiving payment under a Medi-Cal managed care program, the CONTRACTOR shall comply with the provisions of 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610. (42 C.F.R. § 438.600(b)).

2. CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS

   A. CONTRACTOR 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 a provider.

   B. 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.

   C. 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 relevant section below regarding specific requirements for exclusion monitoring.

   D. 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:

      I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;

      II. A history of loss of license or felony convictions;

      III. A history of loss or limitation of privileges or disciplinary activity;

      IV. A lack of present illegal drug use; and

      V. The application's accuracy and completeness

   E. CONTRACTOR must file and keep track of attestation statements for all of their providers and must make those available to the COUNTY upon request at any time.

   F. 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 MH SUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.

G. 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.

3. SCREENING AND ENROLLMENT REQUIREMENTS

A. COUNTY shall ensure that all CONTRACTOR providers are enrolled with the State as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. (42 C.F.R. § 438.608(b))

B. COUNTY may execute this Agreement, pending the outcome of screening, enrollment, and revalidation of CONTRACTOR of up to 120 days but shall terminate this Agreement immediately upon determination that CONTRACTOR cannot be enrolled, or the expiration of one 120-day period without enrollment of the CONTRACTOR, and notify affected clients. (42 C.F.R. § 438.602(b)(2))

C. 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).

Section 6. QUALITY IMPROVEMENT PROGRAM

1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION

A. CONTRACTOR shall comply with the COUNTY'S ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 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.

B. 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 clients' satisfaction 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, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. CONTRACTOR shall measure, monitor, and annually report to the COUNTY its performance.

C. CONTRACTOR shall implement mechanisms to assess client/family satisfaction based on COUNTY'S guidance. The CONTRACTOR shall assess client/family satisfaction by:

I. Surveying client/family satisfaction with the CONTRACTOR'S services at least annually.

II. Evaluating client grievances, appeals and State Hearings at least annually.

III. Evaluating requests to change persons providing services at least annually.

IV. Informing the COUNTY and clients of the results of client/family satisfaction activities.

D. 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.

E. 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.

F. CONTRACTOR shall assist COUNTY, as needed, with the development and implementation of Corrective Action Plans.

G. 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.

H. 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.

I. CONTRACTOR shall assist COUNTY, as needed, with the development and implementation of Corrective Action Plans.

J. 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)

2. NETWORK ADEQUACY

A. The CONTRACTOR shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206 (a), (c)).

B. 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.

C. 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.

D. 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 client the ability to choose the person providing services to them.

3. TIMELY ACCESS

A. CONTRACTOR shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting COUNTY and State Contract standards for timely access to care and services, taking into account the urgency of need for services. The COUNTY shall monitor CONTRACTOR to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.

B. Timely access standards include:

I. CONTRACTOR must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the provider offers services to non-Medi-Cal clients. If the CONTRACTOR'S provider only serves Medi-Cal clients, the provider must 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.

II. Appointments data, including wait times for requested services, must 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 Quality Management Department or other designated persons.

III. Urgent care appointments for services that do not require prior authorization must be provided to clients within 48 hours of a request. Urgent appointments for services that do require prior authorization must be provided to clients within 96 hours of request.

IV. 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) must be made available to Medi-Cal clients within 10 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service. Non-urgent psychiatry appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 15 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service.

V. Applicable appointment time standards may be extended if the referring or treating provider has determined and noted in the client's record that a longer waiting period will not have a detrimental impact on the health of the client.

VI. 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 his or her practice.

4. PRACTICE GUIDELINES

A. CONTRACTOR shall adopt practice guidelines (or adopt COUNTY'S practice guidelines) that meet the following requirements:

I. They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;

II. They consider the needs of the clients;

III. They are adopted in consultation with contracting health care professionals; and

IV. They are reviewed and updated periodically as appropriate (42 C.F.R.§ 438.236(b) and CCR, Title 9, Section 1810.326).

B. CONTRACTOR shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients (42 C.F.R. § 438.236(c)).

5. PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)

A. CONTRACTOR shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal clients 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.

B. 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.

Section 7. CLIENT RIGHTS

1. CONTRACTOR shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code Sections 5325 et seq; Title 9 California Code of Regulations (CCR), Sections 861, 862, 883, 884; Title 22 CCR, Sections 72453 and 72527; and 42 C.F.R. § 438.100.

Section 8. RIGHT TO MONITOR

1. 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, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of CONTRACTOR in the delivery of services provided under this Contract. Full cooperation shall be given by the CONTRACTOR in any auditing or monitoring conducted, according to this agreement.
2. CONTRACTOR shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Contract, 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 Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least ten 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)).
3. 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)).
4. 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.
5. COUNTY reserves the right to place CONTRACTOR on probationary status, as referenced in the Probationary Status Article, should CONTRACTOR fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, 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 contract monitoring and auditing corrective actions are not resolved within specified timeframes.

6. CONTRACTOR shall retain all records and documents originated or prepared pursuant to CONTRACTOR'S performance under this Contract, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten 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, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.
7. CONTRACTOR shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but not be limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.
8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
9. CONTRACTOR shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by COUNTY staff.
10. CONTRACTOR shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.
11. CONTRACTOR shall agree to maintain and retain all appropriate service and financial records for a period of at least ten years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
12. CONTRACTOR shall submit audited financial reports on an annual basis to the COUNTY. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
13. In the event the Agreement is terminated, ends its designated term or CONTRACTOR ceases operation of its business, CONTRACTOR shall deliver or make available to COUNTY all financial records that may have been accumulated by CONTRACTOR or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.
14. 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.
15. 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.

Section 9. SITE INSPECTION

1. 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.

EXHIBIT A-2
FISCAL YEAR 2024/2025

STAFFING

The following list provides the classification and schedule of personnel at CONTRACTOR'S site of service.

JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
	DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO
Program Director/Administrator	M-F			24/7	On call				
Office Manager	M-F			24/7	On call				
Licensed Psychiatric Technician	M-F	7am	3:30pm						
Licensed Vocational Nurse	Sat	7am	3:30pm	Sun	7am	3:30pm	Mon	7am	3:30pm
Licensed Vocational Nurse	M-F	11pm	7:30am	M-F					
Licensed Vocational Nurse	M-F	3:30pm	11:30pm						
Licensed Vocational Nurse	Sat	3pm	11:30p	Sun	3pm	11:30p			
Transition Specialist	M-F	7am	3:30pm						
Therapist	M-F	7am	3:30pm						
Therapist	Per	diem							
Therapist	M-F	8am	4:30pm						
Mental Health Tech/Peer Support Specialist	Sat/Sun	7am	3:30pm	TH	7am	3:30pm	F	7am	3:30pm
Mental Health Tech/Peer Support Specialist	M-F	7am	3:30pm						
Mental Health Tech/Peer Support Specialist	M-F	3pm	11:30p						
Mental Health Tech/Peer Support Specialist	M-F	3pm	11:30p						
Mental Health Tech/Peer Support Specialist	M-Th	11pm	7:30pm						
Mental Health Tech/Peer Support Specialist	MTW	3pm	11:30p						
Mental Health Tech/Peer Support Specialist	Sat-W	7am	3:30pm						
Mental Health Tech/Peer Support Specialist	Th-Sun	3:30pm	11:30p						
Mental Health Tech/Peer Support Specialist	F-Sun	11pm	7:30am						
Mental Health Tech/Peer Support Specialist	W-F	3pm	9pm	Sat	11pm	7:30am	Sun	11pm	7:30am
Mental Health Tech/Peer Support Specialist	M-F	7am	3:30pm						
Mental Health Tech/Peer Support Specialist	Sat/Su	3pm	11:30p	M-T	3-9pm				
Counselor	T-Sat	9am	5:30pm						
Counselor	T-Sat	9am	5:30pm	T-Sat					
Mental Health Tech/Peer Support Specialist	Per	Diem							
Mental Health Tech/Peer Support Specialist	Per	Diem							

EXHIBIT B
FINANCIAL TERMS
BH-TC OPCO, LLC, DBA JACKSON HOUSE TULARE
FISCAL YEAR 2024/2025

1. COMPENSATION
   A. COUNTY agrees to compensate CONTRACTOR for allowed costs. The maximum contract amount shall not exceed Three Million Dollars ($3,000,000) for Fiscal Year 2024/25.
   B. Notwithstanding any other provision of this Agreement, in no event shall COUNTY pay CONTRACTOR more than the maximum contract amount for CONTRACTOR's performance hereunder without a properly executed amendment.
   C. If the CONTRACTOR is going to exceed the maximum contract amount due to additional expenses, it is the responsibility of the CONTRACTOR to request the amendment and provide all supporting documentation that substantiates the increase. No amendments can be requested after April 1, 2025.
   D. CONTRACTOR agrees to comply with Medi-Cal requirements as set forth in the applicable Behavioral Health Information Notices found on the MedCCC library (https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx) as well as all applicable Tulare County Policy and Procedures (P&Ps) related to the delivery of Specialty Mental Health (SMH) services. Additionally, services eligible for reimbursement must otherwise comply with all other terms of this Agreement. To receive a full list of current P&Ps related to the delivery of SMH services, contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.
   E. CONTRACTOR shall be responsible for verifying the Consumer's Medi-Cal eligibility status and will take steps as described in the applicable Tulare County P&P to reactivate or establish eligibility where none exists. To receive a copy of the latest P&P related to the activation of a consumer's Medi-Cal

insurance, please contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.

F. CONTRACTOR shall certify that all Units of Service (UOS) listed on the invoice submitted by the CONTRACTOR for any payor sources covered by this Agreement are true and accurate to the best of the CONTRACTOR'S knowledge.

G. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in the Scope of Services exhibit of this Agreement.

H. COUNTY reimburses CONTRACTOR a prospective fee for services provided within the scope of this Agreement. Any third-party revenues generated from the delivery of services are, therefore, generated as the result of services financed by COUNTY and are the property of COUNTY and not CONTRACTOR. Third-party revenues include but are not limited to revenues generated from commercial insurance agencies and/or Medicare.

I. CONTRACTOR agrees that third-party revenues received as the result of performing services within the scope of this Agreement are due to the COUNTY. COUNTY shall perform a reconciliation on a reoccurring or one-time basis, to determine any revenues received by CONTRACTOR from other payor sources. CONTRACTOR agrees to provide COUNTY with any relevant documents necessary to support COUNTY's reconciliation. CONTRACTOR may pay third-party revenues back to COUNTY through a direct payment or may elect to have COUNTY offset CONTRACTOR's final invoice for the fiscal year to recoup the amount from a future invoice.

2. CLAIMING

A. Services rendered under the scope of this Agreement must only be to Tulare County Medi-Cal beneficiaries or uninsured residents, approved by COUNTY on a case-by-case basis.

I. CONTRACTOR shall not request reimbursement from COUNTY for beneficiaries that are residents of another COUNTY.

a. In the event a beneficiary has Out-of-COUNTY Medi-Cal, but resides permanently in Tulare County, CONTRACTOR may include the services provided only when the following have been met:
   i. CONTRACTOR has ensured the beneficiary has reported the address change, and
   ii. CONTRACTOR provides supporting documentation as required in the applicable P&P to verify the address change has been requested. To receive a copy of the current P&P related to updating consumer Medi-Cal insurance, contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.

B. CONTRACTOR shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual currently available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx for documenting and claiming services.

C. CONTRACTOR shall enter claims data into COUNTY's electronic health record (EHR) within fifteen (15) days following the close of the month in which services were rendered. If CONTRACTOR does not have access to COUNTY's EHR, claims data and all required documentation will be forwarded to COUNTY in a format that is reviewed and approved by COUNTY within fifteen (15) days following the close of the month. Claims shall be complete and accurate and must include all required information regarding the claimed services per the Specialty Mental Health Medi-Cal Billing Manual and any applicable Tulare County P&Ps. To Receive a copy of the latest P&P regarding documentation requirements, please contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.

D. CONTRACTOR will submit within ninety (90) days of the expiration or termination date of this agreement (whichever comes first) its final invoice for claimed services to avoid denial for late billing. In the event CONTRACTOR

omitted to include any eligible service on its final invoice for the fiscal year, it may still submit the claims for reimbursement so long as the service meets the 12-month billing limit.

E. 12-month billing limit: Unless otherwise determined by State or Federal regulations. All original (or initial) claims for eligible individual persons under this Agreement must be received by COUNTY within twelve (12) months from the month of service to avoid denial for late billing.

3. INVOICING

A. CONTRACTOR shall invoice COUNTY for SMHS monthly, in arrears, in a format that is reviewed and approved by COUNTY. Invoices shall be based on claims entered into COUNTY's EHR.

B. Monthly payments for SMHS will be based on the units of time associated with each claimed procedure code, multiplied by the per-minute service rate annotated on Exhibit B-1 for the CONTRACTOR's Provider who rendered the service.

C. Invoices shall be provided to COUNTY within fifteen (15) days after the close of the month. Following receipt and provisional approval of a monthly invoice, COUNTY shall make payment within thirty (30) days unless the invoice is subject to terms and conditions stipulated in FINANCIAL SETTLEMENT FOR MEDI-CAL BILLABLE SERVICES section of this Exhibit.

D. Invoices may be submitted to COUNTY:

I. Via mail to:

Tulare County HHSA
5957 Mooney Blvd
Visalia, CA 93277
ATTN: Mental Health Department

II. Electronically to:

TulareMHP@tularecounty.ca.gov.

a. CONTRACTOR will ensure that invoice documentation containing sensitive patient data is encrypted prior to electronic transmission in accordance with local, State, and Federal regulations.

III. The CPT or HCPCS II procedure codes available to claim through COUNTY's EHR are subject to change. COUNTY reserves the right to activate and deactivate codes in the EHR system.

E. COUNTY's payments to CONTRACTOR for the performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities. COUNTY's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this Agreement.

4. FINANCIAL SETTLEMENT FOR MEDI-CAL BILLABLE SERVICES

A. Units of service provided by CONTRACTOR through the performance of this Agreement must meet Medi-Cal claiming requirements. COUNTY shall provide a provisional payment to CONTRACTOR for units of service provided in accordance with the terms of this Agreement. COUNTY will subsequently submit those units of service provided by CONTRACTOR to Medi-Cal.

B. In the event the state or federal government denies any or all claims submitted by COUNTY on behalf of the CONTRACTOR, COUNTY will not be responsible for any payment obligation and, accordingly, CONTRACTOR shall not seek payment from COUNTY and shall indemnify and hold harmless COUNTY from any and all liabilities for payment of any or all denied claims, including those claims that were submitted outside the period of time specified in this Agreement.

C. CONTRACTOR shall be required to reimburse COUNTY for 100 percent (100%) of the provisional payments made by COUNTY to CONTRACTOR for units of service that have been denied by Medi-Cal.

D. COUNTY will perform a quarterly reconciliation of Medi-Cal denied units of service. Within 90 days following the close of each quarter of the current fiscal year term, COUNTY will provide a report to CONTRACTOR detailing the Medi-Cal denials. This report will include details sufficient to communicate the reason Medi-Cal denied the units of service and the amount of the provisional payment COUNTY reimbursed CONTRACTOR for the

unit(s). This report will summarize the total amount due by CONTRACTOR to COUNTY for the denied units of service.

E. CONTRACTOR agrees to reimburse COUNTY for the provisional payment of the denied units of service in one of the following ways:

I. Reimburse COUNTY through a direct payment mailed to:

Tulare County HHSA
5957 Mooney Blvd
Visalia, CA 93277
ATTN: Behavioral Health Department

II. Allow COUNTY to offset (reduce) the total amount due from CONTRACTOR's monthly invoice.

a. If there are insufficient billing amounts due to CONTRACTOR on the next monthly invoice for COUNTY to recoup the amount due, CONTRACTOR must submit a direct payment to COUNTY for the amount due.

5. ADDITIONAL FINANCIAL REQUIREMENTS

A. CONTRACTOR shall comply with all COUNTY, State, and Federal requirements and procedures, as described in Welfare and Institutions Code Sections 5709, 5710 and 14710, relating to: (1) the determination and collection of patient/client fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP) (2) the eligibility of patients/clients for Medi-Cal , Medicare, private insurance, or other third party revenue, and (3) the collection, reporting, and deduction of all patient/client and other revenue for patients/clients receiving services hereunder.

B. Pursuant to Cal. Code Regs., tit. 9, § 1810.365, the CONTRACTOR or an affiliate, vendor, or sub-contractor of the CONTRACTOR shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments.

C. Consistent with 42 C.F.R. § 438.106, the CONTRACTOR or an affiliate, vendor, contractor, or sub-contractor of the CONTRACTOR shall not hold beneficiaries liable for debts in the event that the CONTRACTOR becomes insolvent, for costs of covered services for which the State does not pay the CONTRACTOR, for costs of covered services for which the State or the CONTRACTOR does not pay the CONTRACTOR's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the CONTRACTOR, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

D. CONTRACTOR shall maintain internal financial controls, which adequately ensure proper billing and collection procedures. CONTRACTOR shall identify and maintain a record of payment received from all potential sources, including payments made by commercial or Medicare.

E. COUNTY shall not furnish any payments to the CONTRACTOR if that individual/entity is under investigation for any fraudulent activity. Payments in this manner will be prohibited until such investigations are completed by COUNTY or State.

F. CONTRACTOR must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the United States Department of Health and Human Services may specify.

G. CONTRACTOR agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.

H. Federal Financial Participation, a source of funding used by COUNTY to reimburse CONTRACTOR, is not 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 had reason to know of the exclusion, or to an individual or entity when COUNTY

failed to suspend payments during an investigation of a credible allegation of fraud [42 U.S.C. section 1396b(i)(2)].

I. COUNTY has the right to monitor the performance of this Agreement to ensure the accuracy of reimbursement claims and compliance with all applicable laws and regulations.

J. CONTRACTOR must keep records of services rendered to Medi-Cal beneficiaries for ten years, Per W&I Code 14124.1.

6. CONTRACTOR PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS [IF APPLICABLE]

   A. Funds paid to CONTRACTOR for services rendered under this agreement may not be redirected or transferred to support another program operated by CONTRACTOR except through a duly executed amendment to this Agreement.

7. FINANCIAL AUDIT REPORT REQUIREMENTS AND REASONS FOR RECOUPMENT

   A. See the Quality Management Standards Exhibit of this Agreement for additional terms regarding reasons for recoupment.

   B. COUNTY, its agents, officers, or employees, may conduct financial program audits at any time to ensure provisional payments made to CONTRACTOR are used as described in the terms of this agreement.

   C. The CONTRACTOR shall submit any documentation requested by COUNTY or State in accordance with audit requirements and needs. Requested documentation must be supplied within a reasonable amount of time.

   D. The audit shall be conducted by utilizing generally accepted accounting principles and generally accepted auditing standards.

   E. CONTRACTOR agrees that any repayment or reimbursement that must be made by COUNTY to the State of California or others as a result of an audit or conduct by CONTRACTOR, its agents, officers or employees of the programs or services provided under this Agreement shall be paid by CONTRACTOR, out of its own funds, within thirty (30) days after the parties are notified that repayment or reimbursement is due. For purposes of this

provision, it is agreed that offsets made by the state are included within the phrase "repayment or reimbursement."

F. COUNTY will involve the CONTRACTOR in developing responses to any draft federal or State audit reports that directly impact COUNTY.

G. In the event of overpayments and prohibited payments:

I. CONTRACTOR shall report to COUNTY within sixty (60) calendar days of payments in excess of amounts specified by contract standards.

II. COUNTY may offset the amount of any overpayment for any fiscal year against subsequent claims from the Contractor.

III. Offsets may be done at any time after COUNTY has invoiced or otherwise notified the CONTRACTOR about the overpayment. COUNTY shall determine the amount that may be withheld from each payment to the CONTRACTOR.

IV. CONTRACTOR shall retain documentation, policies, and treatment of recoveries of overpayments due to fraud, waste, or abuse. Such documentation should include timeframes, processes, documentation, and reporting.

H. For pass-through entities:

I. If COUNTY determines that CONTRACTOR is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., CONTRACTOR represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by COUNTY as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. CONTRACTOR shall observe and comply with all applicable financial audit report requirements and standards.

II. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through COUNTY. COUNTY programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.

III. 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 Director. The Director is responsible for providing the audit report to COUNTY Auditor.

IV. CONTRACTOR must submit any required corrective action plan to COUNTY simultaneously with the audit report or as soon thereafter as it is available. COUNTY shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

EXHIBIT B-1
RATES
BH-TC OPCO, LLC, DBA JACKSON HOUSE TULARE
FISCAL YEAR 2024/2025
Outpatient Specialty Mental Health Service Rates

Group Name	Group Description	Hourly Rate	Per Minute Rate
CNS Group	Certified Nurse Specialists	$793.00	$13.22
LPHA Group	LPHAs (MFT LCSW LPCC)/ Intern or Waivered LPHAs (MFT LCSW LPCC)	$415.00	$6.92
LVN Group	Licensed Vocational Nurses	$251.00	$4.18
MD Group	Licensed Physicians	$1,199.00	$19.98
MHRS Group	Mental Health Rehab Specialists	$230.00	$3.83
NP Group	Nurse Practitioners	$793.00	$13.22
OT Group	Occupational Therapists	$407.00	$6.78
OTHER Group	Other Qualified Practitioners	$230.00	$3.83
PA Group	Physicians Assistants	$716.00	$11.93
PEER Group	Peer Support Specialists	$312.00	$5.20
PHARM Group	Pharmacists	$764.00	$12.73
PSY Group	Psychologists (Licensed or Waivered)	$642.00	$10.70
PT Group	Licensed Psychiatric Technicians	$215.00	$3.58
RN Group	Registered Nurses	$648.00	$10.80

24 Hour Services

Procedure Code	Service	Unit	Rate
H0018	Adult Crisis Residential Treatment	Per Day	$600.00

EXHIBIT C

PROFESSIONAL SERVICES CONTRACTS
INSURANCE REQUIREMENTS

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

A. Minimum Scope & Limits of Insurance

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

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

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

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

B. Specific Provisions of the Certificate

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

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

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

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

   c. *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of CONTRACTOR may acquire against the county by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*

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

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

C. Deductibles and Self-Insured Retentions

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

D. Acceptability of Insurance

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

E. Verification of Coverage

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

WAIVERS:

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

(mark **X** if applicable)

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

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

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

Print Name Bruce Figuered Date: 8/6/2024

Contractor Name Jackson House Tulare

Signature DocuSigned by: BDC47BDCB80E494...