

AGREEMENT FOR SERVICES #XXXX
Specialty Mental Health Services

THIS AGREEMENT is made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as “County”) and PROVIDER NAME, a California non-profit public benefit corporation, duly qualified to conduct business in the State of California, whose principal place of business is PROVIDER ADDRESS and whose mailing address is PROVIDER MAILING ADDRESS, (hereinafter referred to as "Provider");

RECITALS

WHEREAS, County has contracted with the State of California (State) to serve as the Mental Health Plan (MHP) for the County of El Dorado. As the MHP, County must provide or arrange for the provision of certain mandated services, including outpatient Specialty Mental Health Services (SMHS) for children and young adults, age twenty-one (21) and under (hereinafter referred to as Clients);

WHEREAS, County has contracted with the State of California (State) through its Performance Agreement to administer behavioral health services in accordance with the Behavioral Health Services Act including but not limited to SMHS;

WHEREAS, it is anticipated that the County will contract with the State to serve as the Behavioral Health Plan (BHP) for the County of El Dorado, which will replace the MHP, due to ongoing integration of mental health and substance use disorder services. As the MHP and later as the BHP, County must provide or arrange for the provision of certain mandated services, including outpatient Specialty Mental Health Services (SMHS) for children and young adults, age twenty-one (21) and under (hereinafter referred to as Clients);

WHEREAS, County has determined that it is necessary to obtain Provider to provide outpatient SMHS for County-authorized Clients who meet the criteria for outpatient SMHS set forth in Welfare and Institutions Code (WIC) Section 5600.3 and California Code of Regulations (CCR) Title 9, Division 1, Chapter 11, Sub-Chapter 3, Article 2, Section 1830.205, on an "as requested" basis for the El Dorado County Health and Human Services Agency (HHSA), Behavioral Health Division;

WHEREAS, County has determined that it is necessary and in its best interest to procure these SMHS services on a single-source basis, pursuant to the single-source procurement exemption authorized under County Board adopted Resolution 017-2026 (Legistar file 26-2044);

WHEREAS, Provider has represented to County that it is specially trained, experienced, expert, and competent to perform the special services described in ARTICLE I, Scope of Work; that it is an independent and bona fide business operation, advertises and holds itself as such, is in possession of

a valid business license, and is customarily engaged in an independently established business that provides similar services to others; and County relies upon those representations;

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable federal, state and local laws;

WHEREAS, County has determined that the provision of such services provided by Provider are in the public's best interest and that there are specialty skills, qualifications, and equipment not expressly identified in County classifications involved in the performance of the work in accordance with El Dorado County Ordinance Code, Chapter 3.13.030(b), El Dorado County Charter, Section 210(b)(6), and/or Government Code Section 31000;

NOW, THEREFORE, County and Provider mutually agree as follows:

ARTICLE I

Scope of Work: In collaboration with County, Provider shall provide SMHS services set forth in this Article and Exhibit A-1 [through Exhibit A-3]), marked "Additional Scope of Services" (collectively, "Additional Scope of Services, Exhibit A") incorporated herein and made by reference a part hereof, to County Clients ("Clients") who meet criteria for Members to Access SMHS Delivery System, as per California Department Health Care Services (DHCS) guidance specified in Behavioral Health Information Notice (BHIN) 26-002 pertaining to youth under the age of twenty one (21), or as this guidance may be amended or superseded by DHCS. Specifically, Provider shall 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.

Provider agrees to be responsible to ensure all provided services and documentation are consistent and in accordance with County's fully executed MHP agreement(s) with the DHCS in effect at the time services are provided ("MHP Agreement"). Upon the County's execution of a BHP agreement(s) with DHCS that replaces the MHP Agreement, Provider agrees to ensure all provided services and documentation are consistent and in accordance with a County executed BHP agreement(s) with DHCS in effect at the time services are provided ("BHP Agreement"). Said agreement(s) are available, or will be available upon execution, under the Behavioral Health Funding and/or Governing Agreements section at <https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources>.

This Agreement establishes two distinct levels of outpatient SMHS services: Full-Service Partnership (FSP) and Non-FSP.

FSP services represent the County's highest level of outpatient care intensity and are reserved for Clients whose clinical, functional, and environmental needs require comprehensive, flexible, team-based support consistent with WIC §§ 5806–5808 and 9 CCR §§ 3620–3620.10. FSP services include enhanced care coordination, higher service frequency, increased engagement with natural and community supports, and the full array of FSP reporting requirements.

Non-FSP services include all other outpatient SMHS delivered under this Agreement. These services are appropriate when a Client's needs can be met through standard therapeutic, rehabilitative, case management, and care coordination services without the expanded supports provided in an FSP level of care.

Provider shall deliver services only at the level of care expressly authorized by County and shall not designate or transition any Client to FSP without written County authorization.

Provider shall ensure:

1. SMHS services shall be made available to Clients twenty-four (24) hours a day, seven (7) days a week, when medically necessary.
2. Provider shall have available twenty-four (24) hours a day, seven (7) days a week an on-call Mental Health Clinician or Rehabilitation Specialist to provide de-escalation support for the Client and their families at the time of crisis.
3. For enrolled Clients, Provider shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Provider shall provide covered SMHS to enrolled Clients to access the SMHS delivery system of the County's Mental Health Plan for members under age twenty-one (21) who meet the criteria as set forth in BHIN 21-073, or as this guidance may be amended or superseded by DHCS.

A. OUTPATIENT SMHS

Provider agrees to furnish the personnel and equipment necessary to provide the following outpatient SMHS services to all eligible individuals under the age of twenty-one (21) referred from the County's Health and Human Services Agency (HHSA) Behavioral Health Division ("Client" or "Member") in accordance with the following terms and conditions. SMHS Client services shall include those services as set forth in Section D, Services and Deliverables, below.

Provider shall offer and document provision of the integrated behavioral health member handbook at the first contact, in accordance with DHCS BHIN 25-042, or as this guidance may be amended or superseded by DHCS. Documentation shall be maintained in the Client record for audit purposes.

Evidence-Based Practice (EBP) Exhibits incorporated into this Agreement through Additional Scopes of Services (Exhibit A series) shall provide only model-specific elements such as fidelity requirements, staffing patterns, treatment phases, service dosage, and training or certification obligations. Exhibit A-1 through Exhibit A-3 shall supplement, and not restate or modify, generally applicable requirements contained in ARTICLE I, Scope of Work, including but not limited to SMHS eligibility, BHIN and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards, documentation and billing requirements, timely access obligations, care coordination expectations, quality improvement requirements, or any other County-wide or State-wide obligation.

In the event of any inconsistency between an EBP Exhibit and ARTICLE I, Scope of Work, Article I shall govern.

B. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

Provider shall comply with all laws and regulations (inclusive of subsections and referenced codes) applicable to the services provided, including, but not limited to, those reference herein and as such laws and regulations may be amended from time to time during the term of this Agreement. Replaced, amended, or new Department of Health Care Services (DHCS)/County Agreements and governing legislation will not necessitate an amendment to this Agreement. Provider agrees to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

1. United States Code (U.S.C.) Title 42, Chapter 7 Social Security;
2. Code of Federal Regulations (CFR) Title 2 Grants and Agreements;
3. CFR Title 42, Subpart D, Section 438.230(c)(2) Medicaid laws, regulations, including sub regulatory guidance and contract provisions
4. CFR Title 42 Public Health;
5. CFR Title 45 Public Welfare;
6. CFR Title 48 Federal Acquisition Regulations System;
7. Balanced Budget Act of 1997;
8. Health Insurance Portability and Accountability Act (HIPAA);
9. California Code of Regulations Title 9 (9 CCR) Rehabilitative and Development Services, inclusive of Chapter 14, Mental Health Services Act, as applicable to all Mental Health Services Act (MHSA) SMHS services;
10. 22 CCR Social Security; and
11. California Welfare and Institutions Code (WIC), Division 5, Part 4 and Part 4.1.

Provider hereby acknowledges and agrees that in providing services pursuant to this Agreement, they are actively involved in an Interagency System of Care and as such, services provision shall be in accordance with WIC, Division 5 Community Mental Health Services, Part 4 The Children's Mental Health Services Act, inclusive of:

1. County Systems of Care and Their Mission WIC 5855;
2. County System of Care Requirements WIC 5865 (b)-(k), WIC 5865.1 items (b)-(g), and WIC 5865.3 items (b)-(d);
3. County Service Standards WIC 5868
4. Services for Children with Severe Mental Illness WIC 5878.1 - 5878.3
5. System Evaluation WIC 5879 - 5883
6. Full-Service Partnership WIC 5887 items (b), (c), (d)(2), (f)-(h).

Services shall be in compliance with all applicable DHCS BHINs and Mental Health & Substance Use Disorder Services Information Notices (MHSUDS IN) inclusive of those referenced herein and as said guidance may be amended or superseded by DHCS. DHCS notices that can be found on their website at <https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral-Health-Information-Notice-%28BHIN%29-Library.aspx>.

C. FACILITIES MEDICAL SITE CERTIFICATION AND CREDENTIALING

1. Site Certification

- a. Provider Selection Criteria: Provider shall comply with the provisions of CCR Title 9, Section 1810.435.

- b. Provider shall comply with the Medi-Cal provider selection criteria set forth in 9 CCR § 1810.435 MHP Individual, Group and Organizational Provider Selection Criteria.
 - c. Provider shall cooperate with the County for audit and inspection of any site owned, leased, or operated by the Provider and used to deliver covered services to members, except that on-site review is not required for a public school or a satellite site, for compliance with Medi-Cal site certification.
 - i. “Satellite site” means a site owned, leased, or operated by an organizational provider at which SMHS are delivered to members fewer than twenty (20) hours per week, or, if located at a multiagency site at which SMHS are delivered by no more than two employees or Providers of the provider.
2. **Certification Required:** Provider shall be certified pursuant to the Short Doyle Medi-Cal (SD/MC) “Provider Re/Certification Protocol” requirements available at <https://www.dhcs.ca.gov/services/MH/Pages/Certifications.aspx>.
 - a. Provider shall maintain current written policies and procedures required by the Short Doyle/Medi-Cal (SD/MC) Provider Certification & Re-Certification Protocol issued by the State.
 3. **Facility Sites Certified:** Provider shall maintain at least the following Medi-Cal Site certified and appropriate facility(ies) for the provision of Outpatient SMHS for Clients referred by County who meet the minimum requirements for Medi-Cal eligibility. Any subsequent facilities added or change to the locations listed below, must be approved by the County in writing, prior to any relocation, closure, or other change in physical location.

Facility Name and Address		
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4. **Accessibility Requirements:** In accordance with the accessibility requirements of section 508 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, Provider must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal Clients with physical or mental disabilities.
5. **Changes to Site Certified Facilities:** Provider shall notify County of any changes that may affect Medi-Cal Site Certification, including but not limited to structural changes, relocation, expansion, closure, identification of staff as ineligible to provide services, or major staffing/organizational structure changes. Such notification shall occur at least forty-five (45) days prior to the change occurring, to the extent possible. If not possible in forty-five (45) days, Provider shall provide County with notification in accordance with the Article titled “Notice to Parties”, herein, within one (1) business day of changes.
 - a. County Authorization: Provider shall not provide Medi-Cal services at any site, other than a satellite site or a public school, prior to receiving authorization from the County to do so, nor may Provider provide services at a site for which the Medi-Cal site certification has expired or otherwise terminated.
 - b. Access to Provider locations: Provider shall provide the Center for Medicare & Medicaid Services (CMS), the State Medicaid agency, the County, and their agents, and/or designated providers with access to Provider locations to conduct unannounced on-site inspections of any and all Provider locations, with the exception of satellite sites.
 - c. Correction of Issues Identified During Inspections: Provider shall be responsible to address any issues identified by County during inspections to meet Medi-Cal

requirements and shall provide County with a record of corrective action(s).

6. Background Checks, Credentialing and Recredentialing of Providers

- a. Provider shall perform a background screening of all employees who may access personal health information (PHI) or personal information (PI) in accordance with MHSUDS IN 18-019 or as otherwise amended or superseded. The screening should be commensurate with the risk and magnitude of harm the employee could cause, with more thorough screening being done for those employees who are authorized to bypass significant technical and operational security controls. The Contractor shall retain each employee's background check documentation for a period of three (3) years.
- b. Providers shall follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
- c. Upon request, the Provider 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, waived, and/or certified.
- d. Provider 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 CFR 438.610 prohibited affiliations
- e. Providers 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.
 - vi. Provider 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.
 - vii. Provider is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
 - viii. Provider 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.
- f. Within 25 days of changes to service provider status, including but not limited to new hire, re-hire, termination, or change of licensure or taxonomy, Provider shall inform County of change through encrypted documentation as directed by County.

7. Screening and Enrollment Requirements

- a. County shall ensure that all 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 Provider, of up to 120 days but must terminate this Agreement immediately upon determination that Provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the Provider, and notify affected Clients (42 C.F.R. § 438.602(b)(2)).
 - c. Provider 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). Provider shall provide evidence of completed consents when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).
 - d. Provider must maintain PAVE enrollment for all applicable rendering staff per DHCS requirements and conduct monthly Office of Inspector General (OIG)/List of Excluded Individuals and Entities (LEIE), Medi-Cal Suspended & Ineligible, National Plan and Provider Enumeration System (NPPES) and death Master File checks, retaining documentation available on request.
8. **Debarment and Suspension Certification**
- a. Federal funds may not be used for any contracted services if Provider is debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any federal department or agency.
 - b. In accordance with Title 45 CFR Part 76.100, Title 42 CFR Sections 1128 and 1128A, Social Security Act; Title 42 CFR Sections 438.214 and 438.610; and Mental Health Letter No. 10-05 and DHCS MHSUDS Information Notice 18-020, or as subsequently amended or superseded, Contractor will comply with the Federal Health and Human Services, Office of Inspector General's requirement that any provider excluded from participation in federal health care programs, including Medicare or Medicaid/Medi-Cal, may not provide services under this Agreement. Payment will be denied for any services provided by a person identified as excluded from participation in federal health care programs.
 - c. Consistent with the requirements of 42 CFR part 455.436, Provider must confirm the identity and determine the exclusion status of all providers (employees and network providers) and any subcontractor, as well as any person with an ownership or control interest through checks of federal and State databases at intervals identified in MHSUDS Information Notice 18-019 as may be amended or replaced. The following identifies these databases:
 - i. Office of Inspector General List of Excluded Individuals/Entities (LEIE)
 - ii. DHCS Medi-Cal List of Suspended or Ineligible Providers
 - iii. Social Security Administration's Death Master File
 - iv. National Plan and Provider Enumeration System (NPPES)
 - v. Excluded Parties List System (EPLS)
 - d. If Provider finds a party that is excluded, it must promptly notify the County (42 CFR Section 438.608(a)(2),(4)) and the County will notify the State, and take action consistent with 42 CFR Section 438.610((d) and cease billing for any services rendered by the excluded provider as of the effective date of the exclusion. Provider shall not certify or pay any excluded provider with Medi-Cal funds, and any such inappropriate

payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

- e. Allowing staff listed in any state or federal database to provide services performed under this Agreement will result in corrective action.
- f. Provider shall not assign or continue the assignment of any employees, agents (including subcontractors), students, or volunteers ("Assigned Personnel") who have been convicted or incarcerated within the prior ten (10) years for any felony as specified in Penal Code Sections 667.5 and/or 1192.7, to provide direct care to Clients.
- g. By signing this Agreement, Provider agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR part 3017, 45 CFR part 76, 40 CFR part 32, or 34 CFR part 85.
- h. Provider shall not knowingly have any prohibited type of relationship with the following:
 - i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 (42 CFR Section 438.610(a)(1)).
 - ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in this section (42 CFR Section 438.610(a)(2)).
- i. By signing this Agreement, Provider certifies to the best of its knowledge and belief, that it and its principals:
 - i. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
 - ii. Have not within a period of three (3) years preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false Statements, or receiving stolen property;
 - iii. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph h (2) herein; and
 - iv. Have not within a three-year period preceding this agreement had one or more public transactions (federal, State or local) terminated for cause or default.
 - v. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - vi. Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- j. If Provider is unable to certify to any of the statements in this certification, Provider shall submit an explanation to the County Contract Administrator, or designee.

- k. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order (FEO) 12549.
 - l. Provider shall provide the County with its System of Award Management Universal Entity Identification (UEI) number, and will be required to register and with the Federal Government's System of Award Management (www.sam.gov); evidence of registration must be provided by the Provider to the County within thirty (30) days of request.
9. **Compliance Program, Including Fraud Prevention and Overpayments**
- a. Provider shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. §438.608 (a)(1), that must include:
 - i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.
 - ii. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the Chief Executive Officer (CEO) and the Board of Directors.
 - iii. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
 - iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.
 - v. Effective lines of communication between the Compliance Officer and the organization's employees.
 - vi. Enforcement of standards through well-publicized disciplinary guidelines.
 - vii. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.
 - viii. The requirement for prompt reporting and repayment of any overpayments identified.
 - b. Provider must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Provider must report fraud and abuse information to the County including but not limited to:
 - i. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7).
 - ii. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).
 - iii. Information about a change in a Client's circumstances that may affect the Client's eligibility including changes in the Client's residence or the death of the Client as per 42 C.F.R. § 438.608(a)(3).
 - iv. Information about a change in Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the

- termination of this Agreement with the Provider as per 42 C.F.R. § 438.608 (a)(6).
- c. Provider shall implement written policies that provide detailed information about the False Claims Act (“Act”) and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
 - d. Provider shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.
 - e. County may suspend payments to Provider if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).
 - f. Provider shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Provider shall return any overpayments to the County within sixty (60) calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

10. Integrity Disclosures

- a. Provider shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by the County, by the Effective Date, each time the Agreement is renewed and within thirty-five (35) days of any change in ownership or controlling interest of Provider. (42 C.F.R. §§ 455.104, 455.105, and 455.106)
- b. Upon the execution of this Agreement, Provider shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within thirty-five (35) days of the change. (42 C.F.R. § 455.104).
- c. Provider must disclose the following information as requested in the Provider Disclosure Statement:
 - i. Disclosure of 5% or More Ownership Interest:
 - a) In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
 - b) In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
 - c) For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
 - d) For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)
 - ii. Disclosures Related to Business Transactions:
 - a) The ownership of any subcontractor with whom Provider has had business

transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.

- b) Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)
- iii. Disclosures Related to Persons Convicted of Crimes:
 - c) The identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
 - d) County shall terminate the enrollment of Provider if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.
- d. Provider must provide disclosure upon execution of Contract, extension for renewal, and within thirty-five (35) days after any change in Provider ownership or upon request of County. County may refuse to enter into an Agreement or terminate an existing Agreement with a Provider if the Provider fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the Provider did not fully and accurately make the disclosure as required.
- e. Provider must provide the County with written disclosure of any prohibited affiliations under 42 C.F.R. §438.610. Provider must not employ or subcontract with providers or have other relationships with providers Excluded from participating in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610.

11. Certification Of Non-Exclusion or Suspension from Participation in a Federal Health Care Program

- a. Provider shall certify by signing this Agreement that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.
- b. Provider shall certify by signing this Agreement that Provider does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610.
- c. Provider shall conduct initial and, unless prearrangements have been made with the County, monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
 - i. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
 - ii. www.sam.gov/portal/SAM - GSA Exclusions Extract
 - iii. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
 - iv. <https://nppes.cms.hhs.gov/> - National Plan and Provider Enumeration System

(NPPES)

- v. any other database required by DHCS or DHHS.
- d. Provider shall certify by signing this Agreement that it does not employ staff or individual Providers/vendors that are on the Social Security Administration's Death Master File. Provider shall check the following database, <https://www.ssdmf.com/> - Social Security Death Master File, prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
- e. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual providers/subcontractors/vendors) potential placement on an exclusions list.
- f. Provider shall screen and periodically revalidate all its network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
- g. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.
- h. If Provider finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

12. Staff Training

- a. Unless otherwise specified under the terms of this agreement, Provider shall, at their own expense, provide all applicable staff training to adhere to the laws and regulations set forth herein.
- b. Provider shall require all new staff in positions designated as "covered individuals," defined below, to complete compliance training within the first thirty (30) days of their first day of work. Provider shall require all covered individuals to attend, at minimum, one (1) compliance training annually.
 - a) These trainings shall be conducted by County or, at County's discretion, by Provider staff, or both, and may address any standards contained in this agreement.
 - b) "Covered individuals" shall mean those staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing or documenting Client care or medical items or services.
- c. Provider shall require all its staff to complete Cultural Competency Training annually (four (4) hours per year). Reports of completion shall be submitted to the County Contract Administrator or designee by December 31 annually.

13. Provider Application and Validation for Enrollment (PAVE)

- a. Provider shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal Clients on behalf of Provider, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, <https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx>, pursuant to 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.
 - i. Interns, trainees, and associates are not eligible for PAVE enrollment.

D. SERVICES AND DELIVERABLES

1. In accordance with WIC 14705.5, and in cooperation with County, Provider shall provide to the County a written certification of a client’s presumed eligibility for SMHS under Medi-Cal within 30 days of first services provided.
2. Provider shall provide services and maintain policies and procedures in compliance with 9 CCR § 1810.410, Cultural and Linguistic Requirements. Provider shall participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all cultural competency standards and requirements. Provider shall participate in the County’s efforts to promote the delivery of services in a culturally competent and equitable manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.
3. Provider shall provide a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service 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.
4. Provider shall provide Client Informing Materials. All Client Informing Materials shall be in compliance with all applicable laws and regulations, inclusive but not limited to 42 CFR §§ 438.62(b)(3) and 438.10; 9 CCR §§ 1810.360(e) and 1810.410(e)(4):
 - a. Basic Information.
 - b. Beneficiary Informing Materials.
 - c. Provider Directory.
5. All program-related written materials must be provided, minimally, in English and the County’s Medi-Cal threshold language, Spanish.
6. **Client Assessment**
 - a. Provider shall submit through secure methods, as directed by County, the following documents within sixty (60) days after the County’s initial authorization, referring the client to Provider, and every six (6) months thereafter during treatment, and at time of discharge, to be completed by the Provider’s clinician as part of the intake process with the client, in accordance with BHIN 23-068, or as this guidance may be amended or superseded by DHCS:
 - i. Ages 6-20: California Child and Adolescent Needs and Strengths (CANS) 50, or

- the CANS Integrated Practice (CANS-IP), in accordance with BHIN 25-035, or as this guidance may be amended or superseded by DHCS.
- ii. Ages 3-18: Pediatric Symptom Checklist-35 (PSC-35).
 - iii. Medi-Cal 7 Domain Assessment including qualifying mental health diagnosis
 - iv. Problem List.
 - v. Timely Access Data Tool – First SMHS Appointment
 - vi. Timely Access Data Tool – First Medication Support Appointment (if applicable).
 - vii. CSI Admission.
 - viii. Eligibility for Pathways to Wellbeing Checklist, Attachment A-1: If a Client is determined to be eligible for Pathways to Well-Being, the Provider shall ensure an initial Child Family Team (CFT) meeting is held to determine the course of treatment, and the Provider shall provide Intensive Care Coordination (ICC) and Intensive Home-based Services (IHBS) services as clinically appropriate. The Provider shall provide ICC-CFTs at a minimum of every ninety (90) days and use the billing code ICC-CFT for those meetings.
 - ix. Care Plan progress note.
- b. Provider shall also provide the Client with the following forms: Notice of Privacy Practices, Guide to Medi-Cal, Informed Consent, Advanced Directive (Clients aged 18 and above), UMDAP, and obtain all necessary signatures verifying receipt of said notices and guides.
 - i. Provider shall comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 CFR §§ 438.604, 438.606, 438.608 and 438.610. (42 CFR §438.600(b)).
 - c. Provider shall ensure that all client medical records include an assessment of each client's need for mental health services.
 - d. Provider shall use the criteria set forth in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the clinical tool to make diagnostic determinations.
 - i. Once a DSM diagnosis is determined, the Provider shall determine the corresponding diagnosis in the current edition of International Classification of Diseases (ICD). Provider shall use the ICD diagnosis code(s) to submit a claim for SMHS services to receive reimbursement from County.
 - 1) Under the early and periodic screening, diagnostic and treatment (EPSDT) mandate in accordance with 42 CFR 440.345, for youth under the age of twenty-one (21), a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required to begin intervention services.
 - 2) 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.
 - ii. Consent to Treat: No services, even Plan Development, can be billed until the Client and appropriately licensed Provider staff have a signed “consent for treatment” from Client. All activities preceding the signed “consent for treatment” are to be documented in the chart and NOT invoiced to the County. [Note: it is fraudulent to back-date a “consent for treatment.”]

7. Client Services

Provider shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welfare & Inst. Code 14184.402 (d)). Provider shall ensure clients receive timely mental health services and co-occurring treatment services, in accordance with the County's MHP agreement with DHCS, without delay. SMHS shall be provided to the individual Client and may include family/parents/caregivers/guardians, or other significant support persons. Client services may include, but are not limited to, the following:

- a. Case Management
- b. Family Therapy or Rehabilitation.
- c. Assessment.
- d. Individual Therapy.
- e. Individual Rehabilitation.
- f. Group Therapy.
- g. Group Rehabilitation.
- h. Medication Support Services.
- i. Crisis Intervention.
- j. Therapeutic Behavioral Services (Clients under age twenty-one (21) only).
- k. Plan Development.
- l. Intensive Care Coordination (ICC) (Clients under age twenty-one (21) only).
- m. Intensive Home-Based Services (IHBS) (Clients under age twenty-one (21) only).
- n. Non-Mental Health Supportive Services and Goods:
 - i. Non-Mental Health Supportive Services and Goods may be utilized to support the client by providing services and/or goods that fall outside of the client's medical necessities. These may include but are not limited to transportation support and vehicle repairs, over-the-counter medications and non-mental health medical procedures, extra-curricular and recreational activities, education and professional development support, and client engagement incentives including meals and snacks.
 - ii. Upon receipt of the referral packet from the El Dorado County Behavioral Health Division (EDC BHD), the Provider shall attempt to set a treatment appointment with the referred Client as follows:
 - a) Psychiatric Appointments: within fifteen (15) business days from receipt of referral to appointment
 - b) Other Outpatient SMHS: within ten (10) business days from receipt of referral to appointment for all other outpatient SMHS.
 - c) Provider shall follow up with any open client within seven (7) days of release from an inpatient facility to provide am SMHS services.
 - d) Provider shall maintain documentation in the chart to record all attempts at outreach to the family and the outcome of each attempt.
 - iii. Provider shall collaborate with all parties that may be involved with the Client and family, including but not limited to parents, schools, doctors, social services, County Child Welfare Services (CWS), Alta Regional, County Substance Use Disorder Services, and County Probation.
 - iv. Coordination Of Care:
 - a) Provider 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) Provider shall ensure that care coordination activities support the monitoring and treatment of comorbid substance use disorder and/or health conditions.
- c) Provider 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) Provider shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
- e) To facilitate care coordination, Provider shall 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.
- f) Provider shall ensure that families are offered training and given information that will support them in their roles as active, informed decision-makers for and with their family member who is the Client.
- g) Provider shall provide referrals and/or facilitate linkage to community-based and social service organizations for needs such as housing, food, clothing, and transportation as may be appropriate based upon Client needs.
- h) To the extent required based upon Client's legal status, Provider shall insure that all staff accompanying a Client into the community as a part of SMHS delivery will maintain ongoing supervision and care for the Client throughout the service event, to include receiving the Client from, and returning the Client, to Client's current placement, and advising the appropriate responsible adult of the Client's return. Provider shall develop and maintain a policy and procedure reflecting this requirement and submit any updates to the Contract Administrator.
- i) In the event a Client is placed in an out-of-county psychiatric emergency facility and is newly referred to Provider or is an existing Client of Provider, Provider shall serve as the main point of contact for all discharge, aftercare and other care coordination for Client.
- j) Provider shall comply with 9 CCR § 3610 items (a)(2) and (3), (b)-(g), §3620, §3620.05 item (a) and (b) in the provision of Full Service Partnership services.

8. Clients Involved in Child Welfare Services (CWS):

- a. Provider shall provide services to Clients involved with CWS if referred to the Provider from the County.
- b. In addition to the requirements set for herein, Provider will provide services to Clients involved in CWS based on Child Welfare outcomes pertaining to safety, permanency, and well-being as per WIC § 10601.2

- c. Services will be provided in collaboration with the Client and family support system including as appropriate, but not limited to, Child Family Team (CFT), Client's parents/caregivers/guardians, education, primary care providers, social services, Alta Regional Center, Substance Use Disorder Services, listed tribe or Indian custodian (if applicable), foster family agency social worker or Short-Term Residential Therapeutic Program (STRTP) representative, Court Appointed Special Advocates (CASA), parent partners, peer advocates, and County Probation/Justice Services.
- d. Families will have a high level of decision-making influence and will be encouraged to use their natural supports. Provider shall involve the CFT and Client support system as appropriate, in all treatment planning and decision making regarding the Client's services as documented in the Client's treatment plan.
- e. Provider shall insure a licensed or license waived Clinician, as defined in the County MHP Agreement, has the primary responsibility for carrying all CWS-involved cases. Provider may use unlicensed or non-waived staff in accordance with County guidelines to provide non-therapy services, including case management services and collateral contact services.
- f. Provider shall provide the Client's CWS Social Worker with a copy of any requested documentation within five (5) business days of receipt of request, pending valid release of information is on file.

9. Telehealth

- a. Provider may use telehealth, when deemed 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 Provider under this Agreement shall include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Provider. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN **23-018**, or as this guidance may be amended or superseded by DHCS.
- e. County may at any time audit Provider's telehealth practices, and Provider shall allow access to all materials needed to adequately monitor Provider's adherence to telehealth standards and requirements.

10. Discharge Criteria and Process

- a. Discharge planning will include regular reassessment of Client functioning, attainment of goals, determination of treatment needs and establishment of discharge goals. When possible, discharge will include treatment at a lower level of care or intensity appropriate to Client's needs and provision of additional referrals to community resources for Client to utilize after discharge.

- b. Provider shall conduct the following discharge process steps for each Client served under this Agreement.
 - i. Engage in discharge planning beginning at intake for each Client served under this agreement.
 - ii. Complete a discharge summary (reason for discharge, discharge diagnosis, discharge remarks, all identifying information) for each Client served under this agreement.
 - iii. Complete final California Child and Adolescent Needs and Strengths – 50 (CANS-50) or CANS Integrated Practice (CANS-IP) when indicated and Pediatric Symptom Checklist (PSC) for each Client served under this agreement.
 - iv. Complete a final Intensive Care Coordination (ICC) with the Client’s Child and Family Team (CFT) (ICC-CFT), when applicable, for each Client served under this agreement.
 - v. Complete Transition of Care Tool, per BHIN-25-020, or as this guidance may be amended or superseded by DHCS, when appropriate, for each Client served under this agreement.
 - vi. In instances when the youth is receiving medication support services from an El Dorado County contracted medication provider, the youth shall not be discharged from the Provider until the youth has been linked with a new medication provider at a lower level of care.

E. RECORDS, AUTHORIZATIONS, REFERRALS, AND DOCUMENTATION REQUIREMENTS

1. Records:

- a. Maintenance of Records: Provider shall maintain proper clinical and fiscal records relating to Clients served under the terms of this Agreement, as required by the Contract Administrator, or designee, 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.
- b. Any documentation requirements appearing in an EBP Exhibit apply only to fidelity-specific or model-specific elements. All Medi-Cal, BHIN, CalAIM, State, and County documentation standards—including assessment timelines, Problem List requirements, progress note standards, and billing documentation—are governed solely by this Article and shall not be modified or replaced by any Exhibit.
- c. Provider shall maintain all Client records utilizing an Electronic Health Record (EHR) in compliance with the Health Information Technology for Economic and Clinical Health Act (HITECH) (Pub. L. No 111-005).
 - i. Provider may utilize their own EHR at their own expense.
 - ii. If mutually agreed upon by Provider and County, Provider may utilize County’s EHR at no additional cost.
 - a) Provider’s personnel shall adhere to the guidelines outlined in Exhibit G marked, "General Network Usage and Access Procedures and Guidelines" incorporated herein and made by reference a part hereof. Provider’s personnel are required to acknowledge their compliance by signing and returning to

County Contract Administrator, or designee the last page of Exhibit G, marked "El Dorado County Computer and Network Policies Agreement". This document is provided as an example and is incorporated by reference upon request by the County.

- b) Provider shall provide EHR technical assistance to their staff at their own expense.

2. Services Provided in Language other than English:

- a. If services are provided to a Client in a language other than English, Provider shall document the use of an alternate language in the Client's clinical record and identify the language in which services were provided.
- b. In the event of the use of an interpreter service in the provision of SMHS, Provider shall document in the Clients' clinical record the name of the interpreter service and the language utilized.

3. Service Authorization

- a. Provider shall collaborate with County to complete service authorization requests in line with County and DHCS policy.
- b. Provider shall follow county authorization protocols and any additional screening or eligibility criteria required for evidence-based practice implementation, as directed by County.
- c. Provider 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.
- d. Provider shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
- e. County will provide Provider with written notice of authorization determinations within the timeframes set forth in BHINs 22-016 and 22-017, or as this guidance may be amended or superseded by DHCS.
- f. Provider 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.

4. Referrals

a. County Authorizations for Service(s):

- i. For the required referral and services authorizations, Provider shall obtain County authorization.
- ii. Provider shall refer all new requests for SMHS to the COUNTY. These referrals can be made via walk-in, phone call, encrypted file transfer process, or secure fax as follows:
 - a) Via secure fax to:
El Dorado County Behavioral Health Division
Reference: SMHS Referral or Authorization Request
Fax: 530-303-1526
 - b) Via telephone by referral call to:
El Dorado County Behavioral Health Division front desk at (530) 621-6290
 - c) Via secure Email to:
Email: BHDchildrens@edcgov.us OR edcmh-referral@edcgov.us

Attention: El Dorado County Behavioral Health Division
Reference: SMHS Referral or Authorization Request

- d) Via walk-in referral at the office located at:
768 Pleasant Valley Road, Suite 201, Diamond Springs, CA 95619
 - e) For non-Child Welfare Services Clients, the parent or legal guardian, or an organization or agency such as a school or primary care provider, is to phone and request mental health services: Western Slope Region (530) 621-6324 or South Lake Tahoe Region (530) 573-7970.
- iii. County will provide authorization to Provider within seven (7) business days of completed qualifying screening tool, dependent on eligibility.
- a) Determination of Medi-Cal eligibility will be conducted by the County, Mental Health Clinicians unless delegated otherwise by County.
 - b) If eligibility is established, COUNTY will provide a referral packet to the Provider. The referral packet provided by County to Provider will contain the following documentation:
 - (a) Admission and Client and Services Information (CSI) Data Sheet.
 - (b) Summary of presenting problem/reason for request for SMHS with progress note completed by El Dorado County Behavioral Health Clinician.
 - (c) Initial sixty (60)-day authorization
 - c) In cases in which there is more than one (1) individual in the same family receiving mental health services, each individual shall be a separate Client.
 - d) Provider shall not provide services to Client outside of the authorized service dates identified on County authorization.
 - e) Provider shall ensure referral processes align with County protocols and incorporate any evidence-based practice-specific intake or eligibility requirements, as applicable.
- b. **Request For Medication Support Services**
- i. Provider may provide medication supports services through psychiatrist as Provider staff. In the absence of a Provider Psychiatrist, Provider may request Medical Support Services from County.
 - ii. Based on a Client's clinical need, Provider shall submit a referral request to County to request medication support from a County Psychiatrist, using the secure email, fax, or encrypted file transfer process identified above.
 - a) County will make final determination to refer Client to County Psychiatrist.
 - b) County Psychiatrist will provide clinical assessment and, only if deemed appropriate, prescribe psychotropic drugs.
 - iii. Provider shall maintain services with Client as long as County Psychiatrist is prescribing medication. Provider is responsible for providing linkage services to connect Client with community-based medication provider (e.g. primary care physician, Managed Care Plan) before discharging from services.
 - iv. Provider Psychiatrist is permitted to provide only medication management services during the period in which they are actively working to connect Client with a community-based medication provider.
5. **Availability Of Services:**
- a. In accordance with CCR, Title 9, Section 1810.405, Provider shall:
 - i. Comply with timely access requirements for services as established by the State,

Agreement, except in the circumstances specified in BHIN 23-068, or as this guidance may be amended or superseded by DHCS, and in accordance with any additional guidance issued by DHCS that may follow after execution of this Agreement.

7. Progress Notes

- a. Provider 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 23-068, or as this guidance may be amended or superseded by DHCS, whether the note be for an individual or a group service.
- d. Provider 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 twenty-four (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. Request to Move Client to Higher/Lower-Level of Service Program

- a. Based on a Client’s clinical need, Provider shall submit a completed “Program Transfer Request Form,” included herein (Attachment A-2), to County to request to move a Client to a higher or lower level of care.
- b. County will make the final determination to authorize a higher/lower-level of service.
- c. Periodically, and minimally upon request for treatment reauthorization, County shall review Client charts for appropriate levels of care.
- d. The El Dorado County Children’s System of Care is designed to retain Clients in services with the same Contracted Provider when their clinical needs are subject to an increase or a decrease in service intensity for SMHS. By allowing this flexibility within the program, children, youth and their families are able to retain their relationship with their contracted Provider and are not required to transfer to another outpatient program as their needs fluctuate or change.

9. Referral to alternate service modalities

- a. Provider shall submit referral, based on Client’s clinical need, for all EBPs required through EPSDT entitlements, including High Fidelity Wraparound (HFW), Multi-systemic Therapy (MST), Parent Child Interaction Therapy (PCIT), Functional Family Therapy (FFT), or other required EBPs determined by DHCS.
 - i. Following County authorization, referring Provider shall engage in clinical coordination with County and EBP service provider to facilitate clinically appropriate transfer of services in a timely manner.
 - ii. In the event County authorization transfers services to an alternative Provider, the referring Provider shall work towards client discharge within thirty (30) days.
- b. Provider shall submit referral, based on Client’s clinical need for Therapeutic Behavioral Services (TBS).

10. Reauthorization for Continued Services:

- a. Prior to the expiration of the County’s initial authorization for services, as needed, Provider shall seek continued authorization from County for continued services as follows:
 - i. Provider shall submit the Client Reauthorization Packet to the County no later than

- 60 days after the initial authorization is provided by the County.
- ii. Reauthorization should be requested no later than six (6) months from completion of the initial California Child and Adolescent Needs and Strengths(CANS) and Pediatric System Checklist (PSC) completion date.
- iii. The Reauthorization Packet must include the following forms:
 - a) Updated CANS-50 or CANS-IP
 - b) Pediatric System Checklist (PSC)-35

Once a complete reauthorization packet is received by the County, the assigned staff will conduct an audit of the chart to confirm compliance with medical necessity, treatment planning, and progress note documentation.

Upon approval of continuation of services, Provider will receive emailed reauthorization from County for (six) 6 months of continued services from the date of completion of the CANS 50 and PSC 35 tools, whichever was completed first.

11. **Transition of Care Tool**

- a. Provider shall use a Transition of Care Tool for any Clients whose existing services will be transferred from Provider to an Medi-Cal Managed Care Plan (MCP) provider or when Non-SMHS will be added to the existing mental health treatment provided by Provider, as specified in BHIN 25-020, or as this guidance may be amended or superseded by DHCS, in order to ensure continuity of care.
- b. Provider 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 CFR § 438.62(b)(1)-(2).)
- c. 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.
- d. Provider may directly use the DHCS-provided Transition of Care Tool, found at <https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx>, or obtain a copy of that tool provided by the County. Provider may create the Transition of Care Tool in its Electronic Health Record (EHR). However, the contents of the Transition of Care Tool, including the specific wording and order of fields, shall remain identical to the DHCS provided form. The only exception to this requirement is when the tool is translated into languages other than English.

F. **QUALITY IMPROVEMENT, CONTRACT MONITORING, AND AUDITING**

1. **Quality Improvement**

- a. Provider shall comply with the County’s ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 CFR § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
- b. EBP Exhibits may require additional fidelity monitoring or COE reporting; however, all County QI, QAPI, PIP, compliance, audit, and credentialing requirements remain governed by this Article.

- c. Provider shall participate in fidelity monitoring and incorporate evidence-based practice quality measures into its Quality Improvement activities.
 - d. Provider 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. Provider shall measure, monitor, and annually report to the County its performance.
 - e. Provider shall implement mechanisms to assess Client/family satisfaction based on County's guidance. Provider shall assess Client/family satisfaction by:
 - i. Surveying Client/family satisfaction with the Provider'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.
 - f. Provider, 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.
 - g. Provider, if applicable, shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Provider shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Provider at least annually and shared with the County.
 - h. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.
 - i. Provider 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.
 - j. Provider 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. Provider shall ensure that there is active participation by the Provider's practitioners and providers in the QIC.
 - k. Provider 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 CFR §438.350(a) and 42 CFR §438.320)
2. **Network Adequacy**
- a. Provider shall meet Network Adequacy standards as set forth in BHIN 22-032 and 23-060, or as this guidance may be amended or superseded by DHCS.
 - b. In accordance with BHIN 22-032, or as this guidance may be amended or superseded by DHCS, Provider shall submit, when requested by County and in a manner and

format determined by the County, network adequacy certification information to County, utilizing a provided template or other designated format.

- c. Provider 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. Significant changes include, but are not limited to, changes in services or providers available to Clients, and changes in geographic service area.

3. **Auditing**

- a. Provider and County mutually agree to maintain the confidentiality of Provider's Client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA and WIC 5328, to the extent that these requirements are applicable. Provider shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.
- b. Access to Records: Provider shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Provider shall allow County, DHCS, 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 Provider pertaining to such services at any time and as otherwise required under this Agreement.
- c. Provider'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.
- d. Provider's records shall be maintained as required by the Contract Administrator, or designee and DHCS on forms furnished by DHCS or County. All statistical data or information requested by the Contract Administrator, or designee, shall be provided by the Provider in a complete and timely manner.
- e. Provider 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 program, fiscal, or chart reviews and/or audits.
- f. In addition, Provider shall comply with all requests for any documentation or files including, but not limited to, Client and personnel files.
- g. Provider 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.
- h. Provider agrees to maintain and preserve, until ten (10) years after termination of this agreement and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records.
- i. Provider shall allow inspection, evaluation and audit of its records, documents and facilities for ten (10) years from the term end date of this Agreement or in the event Provider 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 CFR § 438.3(h) and 42 C.F.R § 438.230(c)(3)(i-iii).

- a. Reasons For Recoupment
 - i. County may conduct periodic audits of Provider files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and County regulations.
 - ii. Such audits may result in requirements for Provider to reimburse County for services previously paid in the following circumstances:
 - a) Identification of Fraud, Waste or Abuse as defined in federal regulation.
 - 1) Fraud and abuse are defined in 42 CFR §455.2 and WIC 14107.11, subdivision (d).
 - 2) Definitions for “fraud,” “waste,” and “abuse” can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.
 - b) Overpayment of Provider by County due to errors in claiming or documentation.
 - c) Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.
 - d) Provider shall reimburse County for all overpayments identified by Provider, 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.
4. **Reporting and Evaluation Requirements**
- a. Provider shall complete and submit all reporting and evaluation activities as required or requested by the County or DHCS, including but not limited to: Monthly Service Verification, as included herein (Attachment A-3).
 - b. Provider shall administer Consumer Perception Surveys in accordance with 9 CCR §3530.40 Consumer Perception Semi-Annual Survey and BHIN 24-009 Mental Health Consumer Perception Survey Data Collection or as otherwise amended or superseded.
 - c. Other Client Satisfaction Surveys: Within fifteen (15) days of the end of each quarter, Provider shall submit to the County the results of any other Client Satisfaction Survey(s) administered by Provider to Clients referred to Provider from the County.
 - d. Provider shall submit all required fidelity and outcome reports associated with evidence-based practices implemented under this Agreement, in addition to SMHS and County reporting requirements.
 - e. Aggregated CANS and PSC Data.
5. **Reporting Unusual Occurrences or Events of a Serious Nature**
- a. Provider shall report unusual occurrences to the County Contract Administrator or designee. An unusual occurrence is any event which jeopardizes the health and/or safety of Clients, staff and/or members of the community, including, but not limited to, physical injury and death.
 - b. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
 - i. Complete written description of event including outcome;
 - ii. Written report of Provider’s investigation and conclusions; and
 - iii. List of persons directly involved and/or with direct knowledge of the event.
 - c. County and DHCS retain the right to independently investigate unusual occurrences, and Provider shall cooperate in the conduct of such independent investigations.

- d. Occurrences of a Serious Nature: Provider shall notify County Contract Administrator, or designee in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature. For the purpose of this Agreement an occurrence of a serious nature shall include, but is not be limited to, accidents, injuries, acts of negligence, acts that are reportable to a governing body, hospitalizations, any event that impacts delivery of services to Client(s), events that are usually or reasonably preventable, and of a nature such that the risk impacts the provision of services and/or this Agreement for Services or loss or damage to any County property in possession of Provider.
 - i. Notification of Death: Provider shall notify County Contract Administrator, or designee immediately by telephone upon becoming aware of the death of any Client served under this Agreement due to any cause. The Provider shall follow up with a written report faxed or hand-delivered within twenty-four (24) hours of the telephone notification.
 - ii. Notification Content: The Notification of Death shall contain the name of the deceased, the date and time of death, the nature, and circumstances of the death, and the name(s) of Provider’s officers or employees with knowledge of the incident.

G. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

1. All grievances (as defined by 42 CFR §438.400) and complaints received by Provider shall be immediately forwarded to the County’s Quality Management unit or other designated persons via a secure method (e.g., encrypted email, SharePoint, or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
2. Provider 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.
3. Aligned with BHIN 25-014, or as this guidance may be amended or superseded by DHCS and 42 CFR §438.404, the Provider, as the County delegate, shall issue the appropriate Notice of Adverse Benefit Determination (NOABD), within the specified timeframes using the Provider’s letterhead, on templates provided by the County.
4. NOABDs shall be issued to Clients anytime the Provider has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice shall have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Provider shall inform the County immediately after issuing a NOABD. A copy shall be submitted to the County within three (3) business days.
5. Provider shall keep a log of NOABDs and provide it to the County on a quarterly basis, by the 10th of the following month.
6. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 CFR , Part 438, Subpart F (42 CFR §§ 438.400 – 438.424).
7. Provider shall provide Clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and

interpreter services.

8. Provider shall maintain records of grievances and appeals and shall 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.

H. FINANCIAL CLAIMING/REPORTING

1. Claiming

- a. Provider shall enter claims data into the County's billing and transactional database system within the timeframes established by County. Provider shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS SMHS Billing Manual available at <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>, as from time to time amended.
- b. Claims shall be complete and accurate and must include all required information regarding the services claimed.
- c. Provider shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.
- d. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the service rates in Exhibit B, as defined below in Article III, Compensation for Services, Section A, Rates.
- e. County's payments to Provider for performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities.

2. Financial Reporting

- a. On an annual basis, the Internal Revenue Service (IRS) requires organizations to file income tax documents (I.e., Form 990, Form 1040, etc.) that reports income, expenses, and other relevant financial information. In response to federal, state, and County funding requirements and generally accepted accounting principles (GAAP), Provider shall submit copies of these financial documentation reports to County on at least once per annual basis, or upon request, incorporating the following financial information:
 - i. Most recent IRS filing including Statement of Functional Expenses with connected financial statements;
 - ii. Most Recent Financial Statements; and
 - iii. Copy of Financial Audits.
- b. Provider shall prepare financial reports in accordance with all federal, state, and County requirements and generally accepted accounting principles (GAAP).
- c. Provider shall allocate direct and indirect costs to, and between, programs, costs, services, and funding sources in accordance with such requirements and consistent with prudent business practice. Such costs and allocations shall be supported by source documentation maintained by Provider and available at any time to Contract Administrator, or designee upon reasonable notice.
 - i. Provider shall document that costs are reasonable and allowable, and directly or indirectly related to the services provided hereunder.
 - ii. This report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.

- iii. Provider shall provide a copy of any Audit to County within thirty (30) days of completion of said audit, consistent with 45 CFR Subtitle A, Subchapter A, Part 75, Subpart F, as applicable.
- d. Provider shall provide copies of financial reports to the County on an annual basis during the term of this Agreement, within thirty (30) days following the Provider's submission date to the filing agency with notice to the following:

El Dorado County Health and Human Services Agency
Behavioral Health Division
3057 Briw Road
Placerville, CA 95667
Email: hhsa-acct@edcgov.us
Copy: County Contract Administrator

3. Additional Financial Requirements

- a. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
- b. Provider 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 US DHHS may specify.
- c. Provider 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 one (1) of the Executive Schedule at <https://www.opm.gov/> (U.S. Office of Personnel Management), as from time to time amended.
- d. Federal Financial Participation 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 the County failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. §1396b(i)(2)).

4. Provider Prohibited from Redirection of Contracted Funds [If Applicable]

- a. Provider may not redirect or transfer funds from one funded program to another funded program under which Provider provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.
- b. Provider may not charge services delivered to an eligible Client under one funded program to another funded program unless the Client is also eligible for services under the second funded program.

5. Financial Audit Report Requirements for Pass-Through Entities

- a. If County determines that Provider is a "subrecipient" (also known as a "pass-through entity") as defined in 2 CFR § 200 et seq., Provider 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 CFR § 200 et seq., as may be amended from time to time. Provider shall observe and comply with all applicable financial audit report requirements and standards.
- b. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement

- period, and the amount expended during the fiscal year by funding source.
- c. Provider will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the County Contract Administrator, or designee. The County Contract Administrator, or designee, is responsible for providing the audit report to the County Auditor.
 - d. Provider must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.
6. **Applicable Fees**
- a. Provider shall not charge any Clients or third-party payers any fee for service unless directed to do so by the County at the time the Client is referred for services. When directed to charge for services, Provider shall use the uniform billing and collection guidelines prescribed by DHCS.
 - b. Provider will perform eligibility and financial determinations for each member prior to rendering services as well as on a regular basis during service authorization period in accordance with the SMHS Billing Manual, unless directed otherwise by the County.
 - c. Provider shall not submit a claim to, or demand or otherwise collect reimbursement from, the Client or persons acting on behalf of the Client for any SMHS or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (9 CCR, § 1810.365(c)).
 - d. Provider must not bill Clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill Client as set forth in 42 CFR § 438.106.

ARTICLE II

Term: This Agreement shall become effective upon final execution by both parties hereto and shall cover the period of July 1, 2026 through June 30, 2029.

The parties shall have the option to extend the term for one (1) additional one (1) year term after the initial expiration date through June 30, 2030, with the same terms/conditions contemplated in ARTICLE 1, Section 2, Scope of Work, or as amended. The option to extend shall be subject to County Contract Administrator, or designee approval upon written notification in accordance with Article titled "Notice to Parties."

ARTICLE III

Compensation for Services: Provider shall ensure that all claims submitted under this Agreement comply with the medical necessity criteria and documentation standards set forth in the DHCS BHIN(s), including but not limited to BHIN 21-073 and BHIN 23-068, as this guidance may be amended or superseded by DHCS. Provider shall maintain documentation demonstrating that services are medically necessary and consistent with California Advancing and Innovating Medi-Cal (CalAIM) documentation reform requirements, including embedded care planning, problem lists, and progress notes. Provider acknowledges that DHCS guidance may be updated during the term of this Agreement and agrees to implement such updates prospectively upon receipt of County written notice.

- A. **Rates:** For the purposes of this Agreement, the billing rate shall be as defined in Exhibit B and B 1-x marked “Provider Rates,” incorporated herein and made by reference a part hereof (collectively, and referenced herein as, “Provider Rates” or “Exhibit B”).
- B. **In-Lieu-Of Service (ILOS) Rates:** Provider may deliver ILOS consistent with DHCS CalAIM ILOS policy (e.g. medically tailored meals, environmental modifications), as identified and authorized under County’s Model of Care and DHCS pre-approved service list. The County may set separate contracted rates for ILOS, payable upon documented provision of services meeting ILOS criteria.
- C. **Invoices:** It is a requirement of this Agreement that Provider shall submit an original invoice, similar in content and format with the Health and Human Services Agency (HHS) invoice template linked online at <https://ElDoradoCounty.ca.gov/HHSA-Contractor-Resources>, and shall reference this Agreement number on their faces and on any enclosures or backup documentation. Copies of back-up documentation must be attached to invoices shall reflect Provider’s charges for the specific services billed on those invoices.
 - 1. **Billing:** Provider shall submit all services rendered, including Medi-Cal billable services, Medi-Cal non-billable services, and any services otherwise not eligible for third-party reimbursement, through the County’s Step One process. Step One requires submission of the Excel data file and draft invoice via the County’s Secure File Transfer Protocol (SFTP) server or via encrypted email to HHS-Billing@edcgov.us.

County and Provider shall collaborate to resolve eligibility and financial determinations issues consistent with the article titled Scope of Work, Financial Reporting/Claiming section 6. Applicable Fees, item b. Following County review and acceptance of Step One data, Provider may proceed with Step Two invoicing.

The Two-Step invoicing process is as follows:

- a. **Step One:** Provider shall submit an Excel data file with columns as identified below. To avoid federal and state Health Insurance Portability and Accountability Act (HIPAA) violations, County requires that Providers submit Client's protected private health information (PHI) via the County's SFTP server, or by using a secured and encrypted email protocol in compliance with HIPAA security regulations. To gain access the County's SFTP server, please email: HHS-Billing@edcgov.us.

The Excel data file shall include the following information:

- i. First Name.
- ii. Last Name.
- iii. Avatar patient ID
- iv. Admission Date.
- v. Date of Service.
- vi. Practitioner Name.
- vii. Service Code
- viii. Location (for Medi-Cal billable services only)
- ix. Units/Duration/Quantity.
- x. Billed Amount.
- xi. Receipts (as necessary for non-Mental Health Supportive Goods and Services

only)

- b. **Step Two:** County will perform a review and approval of the submitted Excel data file and notify Provider of services approved for billing. Upon approval by County, Provider shall follow Invoice Submittal/Remittance instructions below detailing services approved for billing.

2. **Invoice Submittal/Remittance (All Services):** For services provided herein, including any deliverables that may be identified herein, Provider shall submit monthly invoices no later than thirty (30) days following the end of a "service month" except in those instances where Provider obtains written approval from the HHSA Chief Financial Officer (CFO) or designee granting an extension of the time to complete billing for services or expenses. For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with ARTICLE I "Scope of Work". Invoices shall be submitted with adequate back-up documentation, for review and approval.

Invoices must include the following information:

- a. County Issued Agreement Number.
- b. Provider Name and Address.
- c. Provider Contact Information.
- d. Back up documentation provide by County to include:
 - i. Service Month.
 - ii. Invoice Total.
 - iii. Service totals (Units and Cost total per service code).
 - iv. Receipts (as necessary for non-Mental Health Supportive Goods and Services only)

Invoices shall be sent as follows, or as otherwise directed in writing by County:

<i>Email (preferred method):</i>	<i>U.S. Mail:</i>
<p>BHinvoice@edcgov.us Please include in the subject line: "Contract #, Service Month, Description / Program</p>	<p>County of El Dorado Health and Human Services Agency Attn: Finance Unit 3057 Briw Road, Suite B Placerville, CA 95667-5321</p>

or to such other location as County directs.

For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County's receipt and approval of invoice(s) identifying services rendered.

Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services, previously disallowed services, or inadvertently not submitted services rendered during a month for which a prior invoice has already been submitted to County. Supplemental invoices should include the standard invoice format with description of services rendered. Contractor shall submit all supplemental invoices

for services rendered in a fiscal year before July 31st of the following fiscal year. The County will not accept nor pay any supplemental invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement that are received by County after July 31st of the subsequent fiscal year, unless Contractor requests an exception. Contractor may submit in writing, including electronic communication, to the County Contract Administrator, a request for an exception to pay an invoice received after July 31st of the subsequent year. The Health and Human Services Agency's Chief Fiscal Officer may approve the request in his/her sole discretion.

Upon request from County's Contract Administrator, or designee, Provider shall submit audited financial reports specific to this Agreement within forty-five (45) days of County request. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

- D. Provider shall ensure all services and deliverables, in accordance with the Article titled Scope of Work, are provided in accordance with the County's Performance Agreement with DHCS in effect at the time services are provided. Said agreement is available, and any amendments thereto or superseding Performance Agreement will be available upon execution, under the Behavioral Health Funding and/or Governing Agreements section at <https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources>.
- E. Denied Invoices: SMHS payments shall be made in the amount of the Provider's total claim, minus the amount of denied services. County will submit to Provider the amount of denials received for the prior months' services, as identified on documents received from the State. Provider shall make adjustment for denials on Provider's next submitted invoice.
- F. Rate Updates/DHCS Alignment: Rates for services shall be billed in accordance with Exhibit B "Provider Rates," and are subject to prospective adjustment based on updates to CHCS SMHS Medi-Cal Billing Manual, DHCS Service Tables and Fee Schedules, and County notices. Provider shall implement any such adjustments upon receipt of County written notice issued in accordance with "Notice to Parties," with rates remaining proportional to the previously negotiated Provider Type rates in Exhibit B
- G. Claims Audit/ Program Integrity: All claims submitted under this Agreement are subject to audit and review by County, DHCS, and other authorized entities. Provider shall maintain documentation sufficient to demonstrate compliance with Medi-Cal standards, BHIN requirements, and applicable federal and state regulations, and shall promptly correct any deficiencies or overpayments identified through audits or reviews.

ARTICLE IV

Maximum Obligation: The maximum obligation for services and deliverables provided under this Agreement shall not exceed \$X, XXX,XXX, inclusive of all costs, taxes, and expenses. In the event that the term of this Agreement is extended in accordance with ARTICLE II, Term, the maximum obligation shall be \$X,XXX,XXX.

	Fiscal Year 26/27	Fiscal Year 27/28	Fiscal Year 28/29	Fiscal Year 29/30 (If extended)	Not-to- Exceed
Maximum Obligation:					

The above table represents the total not-to-exceed for this Agreement. Contingent upon written County Contract Administrator, or designee, and Chief Fiscal Officer, or designee approval, County may reallocate the funding among fiscal years. County will provide written notice of any reallocation to Provider consistent with the Article titled “Notice to Parties”

- A. This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or state or federal funding sources that may in any way affect the fiscal provisions of, or funding for this Agreement. This Agreement is also contingent upon sufficient funds being made available by County, state, or federal funding sources for the term of the Agreement.
- B. If the federal or state governments reduce financial participation in the Medi-Cal program, County agrees to meet with Provider to discuss renegotiating the services required by this Agreement.
- C. In no event shall County be obligated to pay Provider for any amount in excess of the maximum obligation per fiscal year of this Agreement. Further, Provider is responsible for managing their Maximum Annual Contractual Obligation by Program and Provider holds the County harmless for Provider over-spending of the Maximum Annual Contractual Obligation by Program.

ARTICLE V

Lobbying Certification: Provider, by signing this Agreement, hereby certifies to the best of his or her knowledge and belief, that:

- A. No federally appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- B. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Provider shall complete and submit Standard Form SF-LLL, OMB Number 0348-0046 “Disclosure of Lobbying Activities” in accordance with its instructions. A copy of Form SF-LLL can be downloaded and completed at <https://www.grants.gov/forms/forms-repository/post-award-reporting-forms>.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. This certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U. S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

ARTICLE VI

Audits, Compliance, and Monitoring:

- A. Provider shall provide a copy of any Audit to County within thirty (30) days of completion of said audit.
- B. Audits and compliance monitoring by any representative of the Federal government, State government, or County may include the review of any and all terms related to this Agreement. Audits or monitoring by the County may be performed by way of annual Contract Monitoring Surveys. Providers receiving a Contract Monitoring Survey shall, within sixty (60) days of receipt, complete and return the survey along with all documentation, details, and supporting materials required by the survey or otherwise necessary for the County to verify compliance with the terms and conditions of the Agreement. Failure to return the survey within the specified time period may result in the withholding of payment from the Provider until such time as compliance with the terms of the Agreement can be verified. Verifying compliance may necessitate additional on-site reviews should information submitted by the Provider be deemed insufficient or inaccurate.
- C. All files, records, documents, sites, and personnel are subject to review by representatives from County, State or federal government.
- D. Upon notification of an exception or finding of non-compliance, the Provider shall submit evidence of Corrective Action within thirty (30) days, or as otherwise specified in the notice of required corrective action provided by the County. Continued non-compliance beyond due date for submission of Corrective Action may lead to termination of this Agreement in accordance with the Article titled "Default, Termination, and Cancellation."
- E. Failure by County to notify or require Corrective Action does not constitute acceptance of the practice of waiver of the County's right to enforce.

ARTICLE VII

Nondiscrimination:

- A. County may require Provider's services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, mental disability, medical condition, genetic information, military or veteran status, marital status, age, gender, gender identity, gender expression, sexual orientation, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, section 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, section 11000 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, section 12990, set forth in Subchapter 5 of Chapter 5 of Division 4.1 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; Title VI of the Civil Rights Act of 1964, as amended. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.
- B. Provider shall, in accordance with Exhibit D, Section 1 (a)-(g) of the Performance Agreement:

1. Post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212). Such notices will state the Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
 2. Provide notice of nondiscrimination in all solicitations or advancements for employees and to labor unions or representatives of employees for which a collective bargaining agreement or other contract exists, and make available all records pertaining to this agreement for the purpose of investigation to ascertain compliance with nondiscrimination rules, regulations and orders. Noncompliance with any rules, regulations or orders may lead to termination of this Agreement in accordance with the Article titled "Default, Termination, and Cancellation."
- C. Where applicable, Provider shall include these nondiscrimination and compliance provisions in any of its agreements that affect or are related to the services performed herein.
- D. Provider's signature executing this Agreement shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, California Code of Regulations, Section 11102.
- E. Provider shall comply with Exhibit #, marked "Vendor Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs," incorporated herein and made by reference a part hereof. Provider shall acknowledge compliance by signing and returning Exhibit # upon request by County.

ARTICLE VIII

Taxes: Provider certifies that as of today's date, it is not in default on any unsecured property taxes or other taxes, or fees owed by Provider to County. Provider agrees that it shall not default on any obligations to County during the term of this Agreement.

ARTICLE IX

Executive Order N-6-22 – Russia Sanctions: On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. "Economic Sanctions" refers to sanctions imposed by the U.S. government in response to Russia's actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, if this Agreement is funded by state funds and County determines Provider is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. The County shall provide Provider advance written notice of such termination, allowing Provider at least thirty (30) calendar days to provide a written response. Termination shall be at the sole discretion of the County.

ARTICLE X

Changes to Agreement: This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

ARTICLE XI

Contractor to County: It is understood that the services provided under this Agreement shall be prepared in and with cooperation from County and its staff. It is further understood that this Agreement does not create an exclusive relationship between County and Provider, and Provider may perform similar work or services for others. However, Provider shall not enter into any agreement with any other party or provide any information in any manner to any other party, that would conflict with Provider's responsibilities or hinder Provider's performance of services hereunder, unless County's Contract Administrator, or designee in writing, authorizes that agreement or sharing of information.

ARTICLE XII

Confidentiality: Provider shall maintain the confidentiality and privileged nature of all records, including billing records, together with any knowledge therein acquired, in accordance with all applicable state and federal laws and regulations, as they may now exist or may hereafter be amended or changed. Provider, and all Provider's staff, employees, and representatives, shall not use or disclose, directly or indirectly at any time, any said confidential information, other than to County's Contract Administrator, or designee for the purpose of, and in the performance of, this Agreement. This confidentiality provision shall survive after the expiration or earlier termination of this Agreement.

ARTICLE XIII

Health Insurance Portability and Accountability Act (HIPAA) Compliance: As a condition of Provider performing services for County, Provider shall execute Exhibit #, marked "HIPAA Business Associate Agreement," incorporated herein and made by reference a part hereof.

ARTICLE XIV

Assignment and Delegation: Provider is engaged by County for its unique qualifications and skills as well as those of its personnel. Provider shall not subcontract, delegate, or assign services to be provided, in whole or in part, to any other person or entity without prior written consent of County. If Provider subcontracts, delegates, or assigns services without prior written consent of the County, this Agreement shall be voided.

In the event Provider receives written consent to subcontract services under this Agreement, Provider is required to ensure subcontractor remains in compliance with the terms and conditions of this Agreement and with the County Agreement with DHCS as applicable. Provider shall require that subcontractors and contracted providers under a contractual, referral, or other arrangement with the Provider not bill Clients for covered services in excess of the amount that would be owed by the individual if the Provider had directly provided the services. (42 U.S.C. Section 1396u-2(b)(6)(C)).) In addition, Provider is required to monitor subcontractor's compliance with said terms and conditions and provide written evidence of monitoring, as well as any corrective action plans issued, to County upon request.

A. Subcontracts:

1. Provider shall obtain prior written approval from the County Contract Administrator before subcontracting any of its obligations to provide services under this Agreement. Approval is at the discretion of the County Contract Administrator but shall not be unreasonably withheld. Provider shall ensure that all subcontracts are subject to the applicable terms and conditions of this Agreement, including, without limitation, the licensing, certification, privacy, data security and confidentiality requirements set forth herein, and include the applicable provisions of 42 Code of Federal Regulations (CFR) 438.230.
2. Provider shall remain legally responsible for the performance of all terms and conditions of this Agreement, including, without limitation, all SMHS services provided by third parties under subcontracts, whether approved by the County or not.
3. Provider shall not subcontract, assign or delegate services to providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. (42 CFR Section 438.214(d).)
4. Any work or services specified in this Agreement which will be performed by other than the Provider shall be evidenced by a written Agreement and contain:
 - i. The activities and obligations, including services provided, and related reporting responsibilities. (42 CFR Section 438.230(c)(1)(i).)
 - ii. The delegated activities and reporting responsibilities in compliance with the Provider's obligations in this Agreement. (42 CFR Section 438.230(c)(1)(ii).)
 - iii. Subcontractor's agreement to submit reports as required by the Provider and/or the County.
 - iv. The method and amount of compensation or other consideration to be received by the subcontractor from the Provider.
 - v. Requirement that the subcontract be governed by, and construed in accordance with, all laws and regulations, and all contractual obligations of the Provider under this contract.
 - vi. Requirement that the subcontractor comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. (42 CFR Section 438.230(c)(2).)
 - vii. Terms of the subcontract including the beginning and ending dates, as well as methods for amendment and, if applicable, extension of the subcontract.
 - viii. Provisions for full and partial revocation of the subcontract, delegated activities or obligations, or application of other remedies permitted by State or federal law when the County or the Provider determine that the subcontractor has not performed satisfactorily. (42 CFR Section 438.230(c)(1)(iii).)
 - ix. The nondiscrimination and compliance provisions of this Agreement.
 - x. A requirement that the subcontractor 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 the subcontract, or determinations of amounts payable available at any time for inspection, examination or copying by the County, DHCS, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and State agencies. (42 CFR Section 438.3(h).) This audit right will exist for ten (10) years from the final date of the

- contract period or from the date of completion of any audit, whichever is later. (42 CFR Section 438.230(c)(3)(iii).) The County, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk. (42 CFR Section 438.230(c)(3)(iv).)
- xi. Inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least ten (10) years from the close of the State fiscal year in which the subcontract was in effect. Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the County.
 - xii. A requirement that the Provider monitor the subcontractor's compliance with the provisions of the subcontract and this Agreement, and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified as set forth in
 - xiii. Subcontractor's agreement to hold harmless the State, County and Clients in the event the Provider cannot or does not pay for services performed by the subcontractor pursuant to the subcontract.
 - xiv. Subcontractor's agreement to comply with the County and Provider's policies and procedures on advance directives.
 - xv. The "Smoke-Free Workplace Certification" will be inserted into any subcontracts entered into that provide for children's services as described in the Pro-Children Act of 1994.
5. Provider shall maintain and adhere to an appropriate system, consistent with federal, State and local law, for the award and monitoring of contracts that contain acceptable standards for insuring accountability.
 6. The system for awarding contracts will contain safeguards to ensure that the Provider does not contract with any entity whose officers have been convicted of fraud or misappropriation of funds; or debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency.
 7. Subcontractors shall comply with the confidentiality requirements set forth set forth herein and include the applicable provisions of 42 Code of Federal Regulations (CFR) 438.230.
 8. Provider shall monitor any subcontractor's compliance with the provisions of this Agreement, and shall provide a corrective action plan if deficiencies are identified.
 9. No subcontract terminates the legal responsibility of the Provider to the County to assure that all activities under this contract are carried out.
 10. Provider shall take positive efforts to use small businesses, minority-owned firms and women's business enterprises, to the fullest extent practicable, including if the Provider subcontracts services pursuant to the ARTICLE titled "Assignment and Delegation." Provider shall:
 - i. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.
 - ii. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

- iii. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.
- iv. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

ARTICLE XV

Independent Contractor: The parties intend that an independent contractor relationship will be created by this contract. Provider is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by the terms of this Agreement. Provider exclusively assumes responsibility for acts of its employees, agents, affiliates, and subcontractors, if any are authorized herein, as they relate to the services or work to be performed under this Agreement during the course and scope of their employment by Provider. Those persons will be entirely and exclusively under the direction, supervision, and control of Provider.

County may designate the tasks to be performed and the results to be accomplished under this Agreement, provide information concerning the work or services, approve or disapprove the final work product and/or services provided, and set deadlines for the completion of the work or services, but County will not control or direct the manner, means, methods, or sequence in which Provider performs the work or services for accomplishing the results. Provider understands and agrees that Provider lacks the authority to bind County or incur any obligations on behalf of County.

Provider, including any subcontractor or employees of Provider, shall not receive, nor be eligible for, any benefits County provides for its employees, including, but not limited to, vacation pay, paid holidays, life insurance, health insurance, social security, disability insurance, pension, or 457 plans. Provider shall not receive, nor be eligible for, workers' compensation, including medical and indemnity payments. County is not responsible for withholding, and shall not withhold, Federal Income Contribution Act amounts or taxes of any kind from any payments which it owes Provider. Provider shall not be subject to the work schedules or vacation periods that apply to County employees.

Provider shall be solely responsible for paying its employees, and for withholding Federal Income Contribution Act amounts and other taxes, workers' compensation, unemployment compensation, medical insurance, life insurance, or any other benefit that Provider provides for its employees.

Provider acknowledges that it has no authority to bind the County or incur any obligations on behalf of the County with regard to any matter, and Provider shall not make any agreements or representations on the County's behalf.

ARTICLE XVI

Fiscal Considerations: The parties to this Agreement recognize and acknowledge that County is a political subdivision of the State of California. As such, County is subject to the provisions of Article XVI, section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment, or services not budgeted in a given

fiscal year. It is further understood that in the normal course of County business, County will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.

Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products, or equipment subject herein. Such notice shall become effective upon the adoption of a final budget, which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated and County released from any further liability hereunder.

In addition to the above, should the County's Board of Supervisors during the course of a given year for financial reasons reduce or order a reduction in the budget for any County department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

ARTICLE XVII

Audit by California State Auditor: Provider acknowledges that if total compensation under this agreement is greater than \$10,000.00, this Agreement is subject to examination and audit by the California State Auditor for a period of three (3) years, or for any longer period required by law, after final payment under this Agreement, pursuant to California Government Code §8546.7. In order to facilitate these potential examinations and audits, Provider shall maintain, for a period of at least three (3) years, or for any longer period required by law, after final payment under the contract, all books, records and documentation necessary to demonstrate performance under the Agreement.

ARTICLE XVIII

Default, Termination, and Cancellation:

- A. Termination by Default: If either party becomes aware of an event of default, that party shall give written notice of said default to the party in default that shall state the following:
1. The alleged default and the applicable Agreement provision; and
 2. That the party in default has ten (10) days upon receiving the notice to cure the default (Time to Cure).

If the party in default does not cure the default within ten (10) days of the Time to Cure, then such party shall be in default and the party giving notice may terminate the Agreement by issuing a Notice of Termination. The party giving notice may extend the Time to Cure at their discretion. Any extension of Time to Cure must be in writing, prepared by the party in default for signature by the party giving notice, and must specify the reason(s) for the extension and the date in which the extension of Time to Cure expires.

If County terminates this Agreement, in whole or in part, for default:

1. County reserves the right to procure the goods or services, or both, similar to those terminated, from other sources and Provider shall be liable to County for any excess costs for those goods or services. County may deduct from any payment due, or that may thereafter become due to Consultant, the excess costs to procure from an alternate source.

2. County shall pay Provider the sum due to Provider under this Agreement prior to termination, unless the cost of completion to County exceeds the funds remaining in the Agreement. In which case the overage shall be deducted from any sum due Provider under this Agreement and the balance, if any, shall be paid to Provider upon demand.
3. County may require Provider to transfer title and deliver to County any completed work under the Agreement.

The following shall be events of default under this Agreement:

1. Failure by either party to perform in a timely and satisfactory manner any or all of its obligations under this Agreement.
 2. A representation or warranty made by Provider in this Agreement proves to have been false or misleading in any respect.
 3. Provider fails to observe and perform any covenant, condition or agreement on its part to be observed or performed under this Agreement, unless County agrees, in writing, to an extension of the time to perform before that time period expires.
 4. A violation of the Article titled "Conflict of Interest."
- B. Bankruptcy: County may terminate this Agreement immediately in the case of bankruptcy, voluntary or involuntary, or insolvency of Provider.
- C. Ceasing Performance: County may terminate this Agreement immediately in the event Provider ceases to operate as a business or otherwise becomes unable to substantially perform any term or condition of this Agreement.
- D. Termination or Cancellation without Cause: County may terminate this Agreement, in whole or in part, for convenience upon thirty (30) calendar days' written Notice of Termination, in accordance with the Article titled "Notice to Parties." If such termination is affected, County will pay for satisfactory services rendered before the effective date of termination, as set forth in the Notice of Termination provided to Provider, and for any other services that County agrees, in writing, to be necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the Agreement. Upon receipt of a Notice of Termination, Provider shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the Notice directs otherwise.

ARTICLE XIX

Notice to Parties: All notices to be given by the parties hereto shall be in writing, with both the County Health and Human Services Agency and County Chief Administrative Office addressed in said correspondence and served by either United States Postal Service mail or electronic email. Notice by mail shall be served by depositing the notice in the United States Post Office, postage prepaid and return receipt requested, and deemed delivered and received five (5) calendar days after deposit. Notice by electronic email shall be served by transmitting the notice to all required email addresses and deemed delivered and received two (2) business days after service.

Notices to County shall be addressed as follows:

with a copy to:

COUNTY OF EL DORADO
 Health and Human Services Agency
 3057 Briw Road, Suite B

COUNTY OF EL DORADO
 Chief Administrative Office
 Procurement and Contracts Division

Placerville, CA 95667
ATTN: Contracts Unit
Email: hhsa-contracts@edcgov.us

330 Fair Lane
Placerville, CA 95667
ATTN: Purchasing Agent
Email: procon@edcgov.us

or to such other location or email as the County directs.

Notices to Provider shall be addressed as follows:

(COMPANY NAME)
(Address)
(City, State, Zip)
ATTN: (Name), (Title)
vendoremail@vendor.com

or to such other location or email as the Provider directs.

ARTICLE XX

Change of Address: In the event of a change in address for Provider 's principal place of business, Provider's Agent for Service of Process, or Notices to Provider, Provider shall notify County in writing pursuant to the provisions contained herein above under the Article titled "Notice to Parties." Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, or designee, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.

ARTICLE XXI

Indemnity: To the fullest extent permitted by law, Provider shall defend at its own expense, indemnify, and hold the County harmless, its officers, employees, agents, and volunteers, against and from any and all liability, claims, suits, losses, damages, or expenses of every name, kind and description, including attorney's fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, County employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the acts or omissions of Provider or its officers, agents, or employees in rendering the services, operations, or performance hereunder, except for liability, claims, suits, losses, damages or expenses arising from the sole negligence or willful acts of the County, its officers and employees, or as expressly prescribed by statute. This duty of Provider to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

The insurance obligations of Provider are separate, independent obligations under the Agreement, and the provisions of this defense and indemnity are not intended to modify nor should they be construed as modifying or in any way limiting the insurance obligations set forth in the Agreement.

Nothing herein shall be construed to seek indemnity in excess of that permitted by Civil Code section 2782, et seq. In the event any portion of this Article is found invalid, the Parties agree that this Article shall survive and be interpreted consistent with the provisions of Civil Code section 2782, et seq.

ARTICLE XXII

Insurance: Provider shall provide proof of a policy of insurance satisfactory to the County of El Dorado Risk Manager and documentation evidencing that Provider maintains insurance that meets the following requirements:

- A. Worker's Compensation covering all employees of Contractor as statutorily required and Employer's Liability Insurance in an amount not less than \$1,000,000.
- B. Commercial General Liability Insurance of not less than \$1,000,000 combined single limit per occurrence for bodily injury and property damage and a \$2,000,000 aggregate limit. County, including, without limitation, its officers, officials, employees, and volunteers shall be named as an additional insured on Insurance Services Office (ISO) form CG 2010 1185, or its equivalent.
- C. Sexual Abuse or Molestation (SAM) Liability: If the work will include contact with minors, and the commercial general liability policy referenced above is not endorsed to include affirmative coverage for sexual abuse or molestation, Provider shall obtain and maintain a policy covering Sexual Abuse and Molestation with a limit no less than \$1,000,000 per occurrence or claim.
- D. Automobile Liability Insurance of not less than \$1,000,000.00 is required in the event motor vehicles are used by the Contractor in the performance of the Agreement.
- E. In the event Contractor is a licensed professional or professional consultant/contractor, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than \$1,000,000.00.
- F. Contractor shall furnish a certificate of insurance satisfactory to the County's Risk Management Division as evidence that the insurance required above is being maintained.
- G. The insurance will be issued by an insurance company acceptable to County's Risk Management Division or be provided through partial or total self-insurance likewise acceptable to the Risk Management Division.
- H. Contractor agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Contractor agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Contractor agrees that no work or services shall be performed prior to the giving of such approval. In the event the Contractor fails to keep in effect at all times insurance coverage as herein provided, County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.
- I. The certificate of insurance must include the following provisions stating that:
 1. The insurer will not cancel the insured's coverage without prior written notice to County; and
 2. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.
- J. Contractor's insurance coverage shall be primary insurance in respect to County, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the

County, its officers, officials, employees or volunteers shall be in excess of Contractor's insurance and shall not contribute with it.

- K. Any deductibles or self-insured retentions must be declared to and approved by County. At the option of County, either: The insurer shall reduce or eliminate such deductibles or self-insured retentions in respect to County, its officers, officials, employees, and volunteers; or Contractor shall procure a bond guaranteeing payment of losses and related investigations, claim administration, and defense expenses.
- L. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.
- M. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.
- N. Contractor's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.
- O. In the event Contractor cannot provide an occurrence policy, Contractor shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.
- P. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of County.

ARTICLE XXIII

Force Majeure: Neither party will be liable for any delay, failure to perform, or omission under this Agreement that is due to any cause that it is beyond its control, not due to its own negligence, and cannot be overcome by the exercise of due diligence. In that event, the affected party will:

- A. Promptly give written notice to the other of the fact that it is unable to so perform and the cause(s) that is beyond its control; and
- B. Once the cause(s) has ceased, provide written notice to the other party and immediately resume its performance under this Agreement.

For purposes of this Article, "cause that is beyond its control" includes labor disturbances, riots, fires, earthquakes, floods, storms, lightning, epidemics, war, disorders, hostilities, expropriation or confiscation of properties, failure of and delays by carriers, interference by civil or military authorities, whether legal or de facto, and whether purporting to act under some constitution, decree, or law, or otherwise, or acts of God.

ARTICLE XXIV

Waiver: No failure on the part of the parties to exercise any rights under this Agreement, and no course of dealing with respect to any right hereunder, shall operate as a waiver of that right, nor shall any single or partial exercise of any right preclude the exercise of any other right. The remedies herein provided are cumulative and are not exclusive of any other remedies provided by law.

ARTICLE XXV

Conflict of Interest: The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and the Political Reform Act of 1974 (Section 87100 et seq.),

relating to conflict of interest of public officers and employees. Individuals who are working for Provider and performing work for County and who are considered to be a Provider within the meaning of Title 2, California Code of Regulations, Section 18700.3, as it now reads or may thereafter be amended, are required to file a statement of economic interest in accordance with County's Conflict of Interest Code. County's Contract Administrator, or designee shall at the time this Agreement is executed make an initial determination whether or not the individuals who will provide services or perform work pursuant to this Agreement are Consultants within the meaning of the Political Reform Act and County's Conflict of Interest Code. Statements of economic interests are public records subject to disclosure under the California Public Records Act.

Provider covenants that during the term of this Agreement neither it, or any officer or employee of the Provider, has or shall acquire any interest, directly or indirectly, in any of the following:

- A. Any other contract connected with, or directly affected by, the services to be performed by this Agreement.
- B. Any other entities connected with, or directly affected by, the services to be performed by this Agreement.
- C. Any officer or employee of County that are involved in this Agreement.

If Provider becomes aware of a conflict of interest related to this Agreement, Provider shall promptly notify County of the existence of that conflict, and County may, in its sole discretion, immediately terminate this Agreement by giving written notice as detailed in the Article titled "Default, Termination and Cancellation."

Pursuant to Government Code section 84308 (SB 1439, the Levine Act), Provider shall complete and sign the attached Exhibit #, marked "California Levine Act Statement," incorporated herein and made by reference a part hereof, regarding campaign contributions by Provider, if any, to any officer of County.

ARTICLE XXVI

California Residency (Form 590): If Provider is a California resident, Provider must file a State of California Form 590, certifying its California residency or, in the case of a corporation, certifying that it has a permanent place of business in California. The Provider will be required to submit a Form 590 prior to execution of an Agreement or County shall withhold seven (7) percent of each payment made to the Provider during term of the Agreement. This requirement applies to any agreement/contract exceeding \$1,500.00.

ARTICLE XXVII

County Payee Data Record Form: All independent Provider or corporations providing services to County who do not have a Department of the Treasury Internal Revenue Service Form W-9 (Form W-9) on file with County must file a County Payee Data Record Form with County.

ARTICLE XXVIII

County Business License: County's Business License Ordinance provides that it is unlawful for any person to furnish supplies or services, or transact any kind of business in the unincorporated territory of El Dorado County without possessing a County business license unless exempt under County Ordinance Code Section 5.08.070. Provider warrants and represents that it shall comply

with all of the requirements of County’s Business License Ordinance, where applicable, prior to beginning work under this Agreement and at all times during the term of this Agreement.

ARTICLE XXIX

Licenses: Provider hereby represents and warrants that Provider and any of its subcontractors employed under this Agreement has all the applicable licenses, permits, and certifications that are legally required for Provider and its subcontractors to practice its profession or provide the services or work contemplated under this Agreement in the State of California. Provider and its subcontractors shall obtain or maintain said applicable licenses, permits, or certificates in good standing throughout the term of this Agreement.

ARTICLE XXX

Contract Administrator: The County Officer or employee with responsibility for administering this Agreement is Christianne Kernes, Deputy Director, Behavioral Health Division, Health and Human Services Agency (HHS), or successor. In the instance where the named Contract Administrator no longer holds this title with County and a successor is pending, or HHS has to temporarily delegate this authority, County Contract Administrator’s Supervisor shall designate a representative to temporarily act as the primary Contract Administrator of this Agreement and HHS Administration shall provide the Provider with the name, title and email for this designee via notification in accordance with the Article titled “Notice to Parties” herein.

ARTICLE XXXI

Authorized Signatures: The parties to this Agreement represent that the undersigned individuals executing this Agreement on their respective behalf are fully authorized to do so by law or other appropriate instrument and to bind upon said parties to the obligations set forth herein.

ARTICLE XXXII

Electronic Signatures: Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement, are intended to authenticate this writing and to have the same force and effect as manual signatures. Electronic Signature means any electronic visual symbol or signature attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including facsimile or email electronic signatures, pursuant to the California Uniform Electronic Transactions Act (Cal. Civ. Code §§ 1633.1 to 1633.17) as amended from time to time.

ARTICLE XXXIII

Partial Invalidity: If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

ARTICLE XXXIV

California Forum and Law: Any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California.

ARTICLE XXXV

No Third Party Beneficiaries: Nothing in this Agreement is intended, nor will be deemed, to confer rights or remedies upon any person or legal entity not a party to this agreement.

ARTICLE XXXVI

Counterparts: This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

ARTICLE XXXVII

Entire Agreement: This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

Requesting Contract Administrator Concurrence:

By: _____
Name
Title
Department

Dated: _____

Requesting Department Head Concurrence:

By: _____
Name
Title
Department

Dated: _____

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates indicated below.

-- COUNTY OF EL DORADO --

Dated: _____

By: _____

Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____
Deputy Clerk

Dated: _____

-- PROVIDER NAME --

By: _____
Name
Title
"Provider"

Dated: _____

By: _____
Corporate Secretary

Dated: _____