AGREEMENT FOR SERVICES #XXXX
Specialty Mental Health Services (SMHS)

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 _____, a _____, duly qualified to conduct business in the State of California, whose principal place of business is _____, and whose Agent for Service of Process is Company name, physical address, (hereinafter referred to as "Provider");

Commented [AAB1]: Required for foreign entities without a local/physical place of business in CA. This is the address where we would serve them legal papers in the event of a breach or other legal action.

RECITALS

WHEREAS, County has contracted with the State of California 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 determined that it is necessary to obtain a 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 on an "as requested" basis for the El Dorado County Health and Human Services Agency (HHSA), Behavioral Health Division;

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

WHEREAS, Provider has represented, through a proposal in response to County's request for proposals or through another means acceptable to the County, that it is able and willing to provide such services;

Commented [AAB2]: If applicable

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; and

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

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EXHIBITS

ARTICLE 1. DEFINITIONS

1. BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN): "Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and providers of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.

2. BENEFICIARY OR CLIENT: "Beneficiary" or "client" means the individual(s) receiving services.

3. DHCS: "DHCS" means the California Department of Health Care Services.

4. DIRECTOR: "Director" means the Director of the County Behavioral Health Department, unless otherwise specified.

ARTICLE 2. GENERAL PROVISIONS

1. TERM
   This Agreement shall become effective upon final execution by both parties hereto and shall cover the period of July 1, 2023 through December 31, 2024.

Commented [AAB3]: Update accordingly

2. SCOPE OF WORK
   Provider shall provide the services set forth in Exhibit A, marked "Scope of Work," incorporated herein and made by reference a part hereof.

3. COMPENSATION FOR SERVICES AND DELIVERABLES
   A. **Rates**: For the purposes of this Agreement, the billing rate shall be as defined in Exhibit B, marked "Provider Rates," incorporated herein and made by reference a part hereof.

   B. **Invoices:** It is a requirement of this Agreement that Provider shall submit an original itemized invoice to be compensated for services. Itemized invoices shall follow the format specified by County Behavioral Health and shall reference this Agreement number on their faces and on any enclosures or backup documentation. Copies of Authorizations and back-up documentation must be attached to invoices shall reflect Provider's charges for the specific services billed on those invoices.

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

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

   or to such other location as County directs.

For services provided herein, including any deliverables that may be identified herein, Provider shall submit invoices for services fifteen (15) days following the end of a "service month."

For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with ARTICLE 2, General Provisions, 2. Scope of Work. 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 itemized invoice(s) identifying services rendered. County may withhold or delay any payment if Provider fails to comply with any provision of this Agreement.

I. **Invoicing** shall be performed in a Two-Step Process *(SMHS Services)*: Provider shall upload to County's Secured File Transfer Protocol (SFTP) server an Excel data file and draft invoice to County for payment.

   a. Step 1: Provider shall submit an Excel data file with columns as identified below. To avoid federal and state 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: HHSA-Billing@edcgov.us.

      The Excel data file shall include the following information:
      1. First Name
      2. Last Name
      3. Client Address
      4. Date of Birth
      5. CIN #
      6. Diagnosis
      7. Admission Date
      8. Date of Service
      9. Practitioner Name
      10. Units/Duration
      11. Billed Amount

   b. Step 2: 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.

II. **Invoice Submittal/Remittance *(All Services)*:** Invoices shall be emailed to BHinvoice@edcgov.us, or as otherwise directed in writing by County. Invoices must include the following information:
   1. County Issued Agreement Number
   2. Provider Name & Address
   3. Service Month
   4. Invoice Total
   5. Service Totals (Units & Cost total per service code)
   6. Provider Contact Information
   7. Written Treatment Authorization (if applicable)

III. **Supplemental Invoices**: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services rendered during a month for which a prior invoice has already been submitted to County. Supplemental Invoices shall follow the two-step process as defined herein above. Supplemental invoices should include the standard invoice format with description of services rendered and a detailed explanation why the invoice was not submitted in the approved timeframe. Written treatment authorization shall be submitted with invoices.

a. For those situations where a service is disallowed by HHSA on an invoice, or inadvertently not submitted on an invoice, and a corrected invoice is later submitted ("Supplemental Invoice"), Supplemental Invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement and received by HHSA after July 31 of the subsequent fiscal year, shall be neither accepted nor paid by the County. Requests for exceptions to pay an invoice received after July 31 of the subsequent year, must be submitted in writing and must be approved by HHSA's Agency Chief Fiscal Officer.

IV. **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.

C. **Incentive Payments for Deliverables**

Provider shall receive a monthly incentive payment for a maximum of 12 months during the first 12-months of the term of this Agreement, contingent upon the Provider meeting the monthly reporting deliverable by submitting a completed Exhibit C, marked "Monthly Incentive Deliverable Data Report," in addition to the monthly invoice to the County Behavioral Health Division.

The data report shall include:

I. For each SMHS service that required travel time, Provider shall report the type of services rendered, the provider type, and the length of travel time.
II. For each SMHS service provided in the threshold language Spanish, Provider shall report the type of the type of service and the provider type.
III. For each Client discharged from an inpatient psychiatric hospital, Provider shall report the length of time from discharge to first outpatient mental health service provided.

Provider's incentive payment will be based on the total number of months in which Provider submitted this report during the first 12 months of this Agreement, even if the data reported is zero.

D. **Compensation for Deliverables**

For deliverables provided herein, Provider shall submit a completed Exhibit C each month for the first twelve (12) months of the Agreement, within fifteen (15) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with ARTICLE 2, General Provisions, 2. Scope of Work. For monthly reports provided herein during the first twelve (12) months of

the Agreement, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County's receipt and approval of the monthly data reports, identifying requested data. County will withhold a deliverable payment if Provider fails to submit the report within this timeframe. Additionally, County may withhold a deliverable payment if Provider fails to comply with any provision of this Agreement.

4. MAXIMUM OBLIGATION

The maximum obligation for services and deliverables provided under this Agreement shall not exceed:

MAXIMUM OBLIGATON FOR SERVICES			
Type of Service	**Fiscal Year 2023/24**	**Fiscal Year 2024/25**	**Not-to-Exceed**
Traditional SMHS	$	$	$
MHSA SMHS	$	$	$
Maximum Services Obligation	$	$	$

	MAXIMUM OBLIGATON FOR INCENTIVE PAYMENTS		
Funding Category	**Maximum Monthly Incentive Payment** *Contingent Upon Meeting Reporting Deliverable	**Maximum Number of Months**	**Total Maximum Deliverable Amount**
MHSA SMHS	$ _____ Per Month Report is Submitted During First 12 Months of Agreement	12	$
	Maximum Incentive Payment Obligation		$

Total Maximum Contractual Obligation: $XXXX, inclusive of all costs and expenses for the term of the Agreement and including maximum incentive upon deliverable payment not to exceed amount.

A. Upon written approval by County's Contract Administrator (or successor), County MHSA staff, and HHSA Fiscal, the amount per fiscal year herein, or the transfer of funds between the funding categories above may be reallocated among fiscal years during the term of this Agreement, contingent upon funding availability. In no event shall the total maximum contractual obligation of the Agreement be exceeded.
B. 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.

C. 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.
D. 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, Contractor is responsible for managing their Maximum Annual Contractual Obligation by Program and Contractor holds the County harmless for Contractor over-spending of the Maximum Annual Contractual Obligation by Program.

5. FEDERAL FUNDING NOTIFICATION

An award/subaward or contract associated with a covered transaction may not be made to a subrecipient or provider who has been identified as suspended or debarred from receiving federal funds. Additionally, counties must annually verify that the subrecipient and/or provider remains in good standing with the federal government throughout the life of the agreement/contract.

Provider agrees to comply with Federal procedures in accordance with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Any costs for which payment has been made to Contractor that are determined by subsequent audit to be unallowable under 48 CFR Part 31 or 2 CFR Part 200 are subject to repayment by Contractor to County.

Consistent with 2 CFR 180.300(a), County has elected to verify whether Contractor has been suspended or using the federal System for Award Management (SAM). The federal SAM is an official website of the federal government through which counties can perform queries to identify if a subrecipient or contractor is listed on the federal SAM excluded list and thus suspended or debarred from receiving federal funds.

A. System for Award Management: Provider is required to obtain and maintain an active Universal Entity Identifier (UEI) No. in the System for Award Management (SAM) system at https://sam.gov/content/home. Noncompliance with this requirement shall result in corrective action, up to and including termination pursuant to the provisions contained herein this Agreement under detailed in ARTICLE 2. General Provisions, 12. Default, Termination and Cancellation.
B. Catalog of Federal Domestic Assistance: Pursuant to the Office of Management and Budget (OMB) Uniform Grants Guidance, all recipients and sub-recipients of federal funds must be provided the Assistance Listing Numbers (ALN) number at the time the contract is awarded. The following are ALN numbers, award specific information, and program titles for programs administered by the County on behalf of California Department of Health Care Services that may apply to this contract:

Federal Funding Information			
Provider:			**UEI #:**
Award Term:			**EIN #:**
Total Federal Funds Obligated: $			
Federal Award Information			
ALN Number	**Federal Award Date / Amount**	**Program Title**	
93.778		Medi-Cal Assistance Program	
Project Description:	SMHS Children's services for referred clients by The County of El Dorado, Health and Human Services Agency.		
Awarding Agency:	California Department of Health Care Services		
Pass-through Entity	County of El Dorado, Health and Human Services Agency		
Indirect Cost Rate or de minimus	Indirect Cost Rate: _____	**De minimus ☒**	
Yes ☐ **No ☒**	Award is for Research and development.		

6. NOTICE TO PARTIES

All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested. Notices to County shall be addressed as follows:

COUNTY OF EL DORADO
Health and Human Services Agency
3057 Briw Road, Suite B
Placerville, CA 95667
ATTN: Contracts Unit
HHSA-contracts@edcgov.us

or to such other location as the County directs.

with a copy to:

COUNTY OF EL DORADO
Chief Administrative Office
Procurement and Contracts Division
330 Fair Lane
Placerville, CA 95667
ATTN: Purchasing Agent

Notices to Provider shall be addressed as follows:

VENDOR NAME
Address
City, State, Zip Code
ATTN:
Vendor.contact@email.com

Commented [AMW4]: Insert vendor email address.

or to such other location as the Provider directs.

7. CHANGE OF ADDRESS
In the event of a change in in organizational name, Head of Service, 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 at least 15 business days in advance of the change, pursuant to the provisions contained in this Agreement under the ARTICLE 2, General Provisions, 6. Notice to Parties. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, 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.
   A. Provider cannot reduce or relocate without first receiving approval by DHCS. A DMC certification application shall be submitted to the DHCS Provider Enrollment Division (PED) 60 days prior to the desired effective date of the reduction of covered services or relocation. Provider shall be subject to continuing certification requirements at least once every five years. Said notice shall become part of this Agreement upon acknowledgment in writing by the County, 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.
   B. Provider must immediately notify County of a change in ownership, organizational status, licensure, or ability of Provider to provide the quantity or quality of the contracted services in a timely fashion.

8. INDEPENDENT PROVIDER
The parties intend that an independent Provider 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 subcontractors 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.

9. 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.

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. In addition, Provider is required to monitor subcontractor's compliance with said terms and conditions and provide written evidence of monitoring to County upon request.

10. SUBCONTRACTS

A. Provider shall obtain prior written approval from the Contract Administrator before subcontracting any of its obligations to provide services under this Agreement. Approval is at the discretion of the 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.
B. 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.
C. 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).)
D. 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 contract, and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified as set forth in ARTICLE 5, Chart Auditing And Reasons For Recoupment, 4. Internal Auditing, Compliance, and Monitoring, of this Agreement.
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.

E. The 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.
F. 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.

G. 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.
H. Provider shall monitor any subcontractor's compliance with the provisions of this Agreement, and shall provide a corrective action plan if deficiencies are identified.
I. No subcontract terminates the legal responsibility of the Provider to the County to assure that all activities under this contract are carried out.
J. 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 ARTICLE 2, General Provisions, 9. 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.

11. 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.

12. 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:
    I. The alleged default and the applicable Agreement provision.
    II. 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:

I. 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 Provider, the excess costs to procure from an alternate source.

II. 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.

III. 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:

IV. Failure by either party to perform in a timely and satisfactory manner any or all of its obligations under this Agreement.

V. A representation or warranty made by Provider in this Agreement proves to have been false or misleading in any respect.

VI. 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.

VII. A violation of ARTICLE 2, General Provisions, 16. 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. If such termination is effected, 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.

E. **Judicial or Administrative Proceedings:** Contractor will notify the County if it is named as a defendant in a criminal proceeding for a violation of the Health Insurance Portability and Accountability Act (HIPAA) or other security or privacy law. The County may terminate this Agreement if Contractor is found guilty of a criminal violation of HIPAA. The County may terminate this Agreement if a finding or stipulation that the Contractor has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Contractor is a party or has been joined. The County will consider the nature and seriousness of the violation in deciding whether or not to terminate the Agreement.

F. **Effect of Termination:** Upon termination or expiration of this Agreement for any reason, the Contractor shall return or destroy all individually identifiable health information (IIHI) received from the State that the Contractor still maintains in any form, and shall retain no copies of such IIHI or, if return or destruction is not feasible, it shall continue to extend the protections of this Agreement to such information, and limit further use of such IIHI to those purposes that make the return or destruction of such IIHI infeasible. This provision shall apply to IIHI that is in the possession of subcontractors or agents of the Contractor.

13. INTERPRETATION; VENUE
    A. The headings used herein are for reference only. The terms of the Agreement are set out in the text under the headings.
    B. This Agreement shall be governed by the laws of the State of California without regard to the choice of law or conflicts.
    C. This Agreement is made in El Dorado County, California. The venue for any legal action in state court filed by either party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement shall be in the Superior Court of California, County of El Dorado. The venue for any legal action in federal court filed by either Party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement lying withing the jurisdiction of the federal courts shall be the 5th District of California.

14. SEVERABILITY
    If any provision of this Agreement, or any portion thereof, is found by any court of competent jurisdiction to be unenforceable or invalid for any reason, such provision shall be severable and shall not in any way impair the enforceability of any other provision of this Agreement.

15. 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. Full Worker's Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.
    B. Commercial General Liability Insurance of not less than $1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a $2,000,000.00 aggregate limit.
    C. Automobile Liability Insurance of not less than $1,000,000.00 is required in the event motor vehicles are used by the Provider in the performance of the Agreement.
    D. In the event Provider is a licensed professional or professional consultant, 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 per occurrence.
    E. Provider shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.
    F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.
    G. Provider 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, Provider 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 Provider agrees that no work or services shall be performed prior to the giving of such approval. In the event the Provider 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.

H. 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.

I. The Provider's insurance coverage shall be primary insurance as respects the 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 the Provider's insurance and shall not contribute with it.

J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Provider shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

K. 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.

L. 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.

M. Provider's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

N. In the event Provider cannot provide an occurrence policy, Provider 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.

O. 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 the County.

16. 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 Consultant within the meaning of Title 2, California Code of Regulations (CCR), 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 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.

The Provider shall comply with the conflict of interest safeguards described in 42 CFR part 438.58 and the prohibitions described in Section 1902(a)(4)(C) of the Public Health Service Act. (42 CFR Section 438.3(f)(2).)

Provider's officers and employees shall not have a financial interest in this Contract or a subcontract of this Contract made by them in their official capacity, or by any body or board of which they are members unless the interest is remote. (GC Section 1090, 1091; 42 CFR Section 438.3(f)(2).)

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 ARTICLE 2. General Provisions, 12. Default, Termination and Cancellation.

Pursuant to Government Code section 84308 (SB 1439, the Levine Act), Provider shall complete and sign the attached Exhibit E, 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.

17. 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 section, "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.

18. SEVERABILITY
If any provision of this Agreement, or any portion thereof, is found by any court of competent jurisdiction to be unenforceable or invalid for any reason, such provision shall be severable and shall not in any way impair the enforceability of any other provision of this Agreement.

19. AUTHORITY TO CONTRACT
County and Provider warrant that they are legally permitted and otherwise have the authority to enter into this Agreement, the signatories to this Agreement are authorized to execute this Agreement on behalf of their respective entities, and that any action necessary to bind each Party has been taken prior to execution of this Agreement.

20. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS
A. Provider shall provide services in conformance with all applicable state and federal statues, regulations and sub-regulatory guidance, as from time to time amended, including but not limited to:
I. Title 9, CCR;
II. Title 22, CCR;
III. California Welfare and Institutions Code, Division 5;
IV. United States Code of Federal Regulations, Title 42, including but not limited to Parts 2, 438 and 455;
V. United States Code of Federal Regulations, Title 45;
VI. United States Code, Title 42 (The Public Health and Welfare), as applicable;
VII. Balanced Budget Act of 1997;
VIII. Health Insurance Portability and Accountability Act (HIPAA); and
IX. Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.
B. In the event any law, regulation, or guidance referred to in subsection (A), above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.
C. **Mandated Reporter Requirements:** Provider acknowledges and agrees to comply with mandated reporter requirements pursuant to the provisions of Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the California Penal Code, also known as "The Child Abuse and Neglect Reporting Act," and the Welfare and Institutions Code Section 15630 et seq., related to elder and dependent adults, as applicable.

ARTICLE 3. SERVICES AND ACCESS PROVISIONS
1. FACILITIES MEDI-CAL SITE CERTIFICATION:
A. Medi-Cal Site Certification: County shall audit Provider's facilities for Medi-Cal site certification, in accordance with DHCS protocol.
B. Certification of Provider as an organizational provider of SMHS shall be in conformance with (SD/MC) "Provider Re/Certification Protocol" requirements available at https://www.dhcs.ca.gov/services/MH/Pages/Certifications.aspx.
C. 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 advance and in writing, prior to any relocation, closure, or other change in physical location.

Facility Address	Enter Facility Address	Enter Second Facility Address if Applicable

Commented [AAB5]: Program to add Facility Addresses for each provider

D. 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.

E. Provider shall comply with the provisions of CCR Title 9, Section 1810.435.

I. Provider shall comply with the requirements of CCR Title 9, Section 1810.435(e) by cooperating with the County for inspection of any site owned, leased, or operated by the Provider and used to deliver covered services to beneficiaries, except that on-site review is not required for a public school or a satellite site.

a. "Satellite site" means a site owned, leased, or operated by an organizational provider at which SMHS are delivered to beneficiaries fewer than 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.

F. 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 ARTICLE 2, General Provisions, 6. Notice to Parties, herein, within one (1) business day of changes.

a. 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. Provider shall provide 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).

2. CERTIFICATION OF ELIGIBILITY

Provider will, in cooperation with County, comply with Section 14705.5 of California Welfare and Institutions Code to obtain a certification of a client's eligibility, to obtain a certification of a client's eligibility for SMHS, including Social Rehabilitation Treatment Services (SRFS), under Medi-Cal.

3. ACCESS TO SPECIALTY MENTAL HEALTH SERVICES

A. In collaboration with the County, Provider will work to ensure that individuals to whom the Provider provides SMHS meet access criteria, as per DHCS guidance specified in BHIN 21-073. Specifically, the Provider will ensure that the clinical record for each client

includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision.

B. For enrolled Clients under 21 years of age, Provider shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled Clients who meet either of the following criteria, (I) or (II) below. If a Client under age 21 meets the criteria as described in (I) below, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (II) below.
   I. The Client has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.
   II. The Client has at least one of the following:
      a. A significant impairment
      b. A reasonable probability of significant deterioration in an important area of life functioning
      c. A reasonable probability of not progressing developmentally as appropriate.
      d. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal Managed Care Plan (MCP) is required to provide AND the Client's condition as described in subparagraph (II a-d) above is due to one of the following:
         1. A diagnosed mental health disorder, according to the criteria in the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases and Related Health Problems (ICD).
         2. A suspected mental health disorder that has not yet been diagnosed.
         3. Significant trauma placing the Client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

C. For Clients 21 years of age or older, Provider shall provide covered SMHS for Clients who meet both of the following criteria, (I) and (II) below:
   I. The Client has one or both of the following:
      a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
      b. A reasonable probability of significant deterioration in an important area of life functioning.
   II. The Client's condition as described in paragraph (I) is due to either of the following:
      a. A diagnosed mental health disorder, according to the criteria in the current editions of the DSM and ICD.
      b. A suspected mental disorder that has not yet been diagnosed.

4. <u>DEBARMENT AND SUSPENSION CERTIFICATION</u>

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.
   I. In accordance with Title 2 CFR Part 376.10, 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.

II. Consistent with the requirements of 42 CFR part 455.436, the 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:
   a. Office of Inspector General List of Excluded Individuals/Entities (LEIE)
   b. DHCS Medi-Cal List of Suspended or Ineligible Providers
   c. Social Security Administration's Death Master File
   d. National Plan and Provider Enumeration System (NPPES)
   e. Excluded Parties List System (EPLS)

III. If the 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. The 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.

IV. Allowing staff listed in any State or federal database to provide services performed under this Agreement will result in corrective action.

V. 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.

VI. By signing this Agreement, the Contractor agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR parts 180 and 417, 2 CFR part 376, 2 CFR part 1532, or 2 CFR part 1485.

VII. The Provider shall not knowingly have any prohibited type of relationship with the following:
   a. 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)).
   b. 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)).

VIII. By signing this Agreement, the Provider certifies to the best of its knowledge and belief, that it and its principals:
   a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

b. 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;
c. 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
d. 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.
e. 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.
f. 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.

IX. If the Provider is unable to certify to any of the statements in this certification, the Provider shall submit an explanation to the County Contract Administrator, or successor.

X. 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.

XI. The 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.

5. ADDITIONAL CLARIFICATIONS

A. Criteria

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

a. The services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process;
b. The service was not included in an individual treatment plan; or
c. The client had a co-occurring substance use disorder.

B. Diagnosis Not a Prerequisite

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

6. MEDICAL NECESSITY
   I. Provider will ensure that services provided are medically necessary in compliance with BHIN 21-073 and pursuant to Welfare and Institutions Code section 14184.402(a). Services provided to a client must be medically necessary and clinically appropriate to address the client's presenting condition. Documentation in each client's chart as a whole will demonstrate medical necessity as defined below, based on the client's age at the time of service provision.
   II. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.
   III. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

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

8. CO-OCCURRING TREATMENT AND NO WRONG DOOR
   A. As specified in BHIN 22-001**,** Specialty and Non-Specialty Mental Health Services can be provided concurrently, if those services are clinically appropriate, coordinated, and not duplicative.
   B. When a client meets criteria for both NSMHS and SMHS, the client should receive services based on individual clinical need and established therapeutic relationships. Clinically appropriate and covered SMHS can also be provided when the client has a co-occurring mental health condition and substance use disorder.
   C. Under this Agreement, Provider will ensure that clients receive timely mental health services without delay.
   D. Services are reimbursable to Provider by County even when:

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

ARTICLE 4. AUTHORIZATION AND DOCUMENTATION PROVISIONS

1. SERVICE AUTHORIZATION
   A. Provider will collaborate with County to complete authorization requests in line with County and DHCS policy.
   B. 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.
   C. Provider shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
   D. County shall provide Provider with written notice of authorization determinations within the timeframes set forth in BHINs 22-016 and 22-017, or any subsequent DHCS notices.
   E. 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.

2. DOCUMENTATION REQUIREMENTS
   A. Provider will follow all documentation requirements in compliance with federal, state and County requirements.
   B. All Provider documentation shall be accurate, complete, and legible, shall list each date of service, and include the face-to-face time for each service. Provider shall document travel and documentation time for each service separately from face-to-face time and provide this information to County upon request. Services must be identified as provided in-person, by telephone, or by telehealth.
   C. All services shall be documented utilizing County-approved templates and contain all required elements. Provider agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this section require corrective action plans.

3. ASSESSMENT
   A. Provider shall ensure that all client medical records include an assessment of each client's need for mental health services.
   B. Provider will utilize the seven uniform assessment domains and include other required elements as identified in BHIN 22-019 and document the assessment in the client's medical record.
   C. For clients aged 6 through 20, the Child and Adolescent Needs and Strengths (CANS), and for clients aged 3 through 18, the Pediatric Symptom Checklist-35 (PSC-35) tools are required at intake, every six months during treatment, and at discharge, as specified in DHCS MHSUDS INs 17-052 and 18-048.

D. Provider shall complete an initial SMHS assessment not later than 60 days after initial authorization has been provided by El Dorado County Behavioral Health Division. Providers shall complete updated assessments when clinically indicated and in accordance with generally accepted standards of practice.

4. ICD-10
   A. Provider shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
   B. Once a DSM diagnosis is determined, the Provider shall determine the corresponding diagnosis in the current edition of ICD. Provider shall use the ICD diagnosis code(s) to submit a claim for SMHS services to receive reimbursement from County.
   C. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.
   D. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by CMS.

5. PROBLEM LIST
   A. Provider will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
   B. Provider must document a problem list that adheres to industry standards utilizing at minimum International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED) U.S. Edition, March 2021 Release, and ICD-10-CM 2023.
   C. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.
   D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
   E. The problem list shall include, but is not limited to, all elements specified in BHIN 22-019.
   F. Provider shall complete an initial Problem List no later than 60 days after the initial authorization has been provided by El Dorado County Behavioral Health Division. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Provider shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the Client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

6. TREATMENT AND CARE PLANS
   A. Provider is not required to complete treatment or care plans for clients under this Agreement, except in the circumstances specified in BHIN 22-019 and additional guidance from DHCS that may follow after execution of this Agreement.
   B. This BHIN 22-019 may be found online at: BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf (ca.gov)

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 22-019, 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 24 hours.
   E. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services, if applicable.

8. TRANSITION OF CARE TOOL
   A. 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 NSMHS will be added to the existing mental health treatment provided by Provider, as specified in BHIN 22-065, in order to ensure continuity of care.
   B. Determinations to transition care or add services from an MCP shall be made in alignment with County policies and via a client-centered, shared decision-making process.
   C. 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.

9. TELEHEALTH
   A. Provider may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
   B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.
   C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.
   D. Medical records for clients served by Provider under this Agreement must 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 22-019.

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

ARTICLE 5. CHART AUDITING AND REASONS FOR RECOUPMENT

1. 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 Director, DHCS, and all applicable state and federal statutes and regulations. Client records shall include but not be limited to admission records, diagnostic studies and evaluations, client interviews and progress notes, and records of services provided. All such records shall be maintained in sufficient detail to permit evaluation of the services provided and to meet claiming requirements.

2. ACCESS TO RECORDS

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, 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.

3. FEDERAL, STATE AND COUNTY AUDITS

In accordance with the Title 9, CCR, Chapter 11, Section 1810.380(a), County will conduct monitoring and oversight activities to review Provider's SMHS programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to SMHS as established in BHIN 21-073, in compliance with the applicable state and federal laws and regulations, and/or the terms of the Agreement between Provider and County, and future BHINs which may spell out other specific requirements.

4. INTERNAL AUDITING, COMPLIANCE, AND MONITORING

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

B. Provider shall provide County with notification and a summary of any internal audit within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, including any exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Provider's internal audit process as applicable.

C. Audits or monitoring by the County may be performed by way of annual Contract Monitoring Surveys. Provider 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.

D. State Audits: 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.

E. The State, CMS the Health and Human Services (HHS) Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents of the County, or its Providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

F. The Provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.

G. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the Provider will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

H. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.

I. 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 ARTICLE 2. General Provisions, 12. Default, Termination and Cancellation.

J. 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.

5. CONFIDENTIALITY IN AUDIT PROCESS

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 California Welfare and Institutions Code 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. 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.

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

6. REASONS FOR RECOUPMENT
   A. County will conduct periodic audits of Provider files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.
   B. Such audits may result in requirements for Provider to reimburse County for services previously paid in the following circumstances:
      I. Identification of Fraud, Waste or Abuse as defined in federal regulation.
         a. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).
         b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.
      II. Overpayment of Provider by County due to errors in claiming or documentation.
      III. Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.
   C. 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.

7. COOPERATION WITH AUDITS
   A. 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.
   B. In addition, Provider shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.
   C. 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.
   D. 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 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).

8. INDEMINITY
   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.

ARTICLE 6. CLIENT PROTECTIONS

1. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION
   A. All grievances (as defined by 42 C.F.R. §438.400) and complaints received by Provider must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
   B. 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.
   C. Aligned with MHSUDS IN 18-010E and 42 C.F.R. §438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Provider within the specified timeframes using the template provided by the County.
   D. NOABDs must 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 must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Provider must inform the County immediately after issuing a NOABD. A copy shall be submitted to the El Dorado County Behavioral Health Division within three (3) business days.
   E. Provider shall keep a log of NOABDs and provide it to the El Dorado County Behavioral Health Division on a quarterly basis.
   F. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
   G. Provider must 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.
   H. Provider must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

2. ADVANCED DIRECTIVES
   Provider must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610. (42 C.F.R. §438.600(b)).

3. CONTINUITY OF CARE
   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 C.F.R. § 438.62(b)(1)-(2).)

ARTICLE 7. PROGRAM INTEGRITY

1. GENERAL
   As a condition of receiving payment under a Medi-Cal managed care program, the Provider shall comply with the provisions of 42 C.F.R. §§438.604, 438.606, 438.608 and 438.610. (42 C.F.R. §438.600 (b)).
2. CREDENTIALING AND RECREDENTIALING OF PROVIDERS
   A. Providers must 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.
   B. 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, waivered, and/or certified.
   C. 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 C.F.R. §438.610. See relevant section below regarding specific requirements for exclusion monitoring.
   D. 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
   E. 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.
   F. 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.
   G. 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.

3. SCREENING AND ENROLLMENT REQUIREMENTS
   A. County shall ensure that all Provider 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).

4. 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 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 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 the 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 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

5. 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 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 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:
a. 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.)
b. 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 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.

6. CERTIFICATION OF NON-EXCLUSION OR SUSPENSION FROM PARTICIPATION IN A FEDERAL HEALTH CARE PROGRAM

A. Prior to the effective date of this Agreement, the Provider must certify 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, prior to the execution of the Contract, that the 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. Provider shall conduct initial and 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.

C. Provider shall certify, prior to the execution of the Agreement, that Provider 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 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.
   I. https://www.ssdmf.com/ - Social Security Death Master File
D. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.
E. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
F. 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.
G. If a 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.

ARTICLE 8. QUALITY IMPROVEMENT PROGRAM

1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION
   A. Provider shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
   B. 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.
   C. Provider shall implement mechanisms to assess client/family satisfaction based on County's guidance. The 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.
   D. 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.

E. 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.
F. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.
G. 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.
H. 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.
I. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.
J. 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 C.F.R. §§ 438.350(a) and 438.320)

2. NETWORK ADEQUACY
A. Provider shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206 (a),(c)).
B. 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.
D. To the extent possible and appropriately consistent with CCR, Title 9, §1830.225 and 42 C.F.R. §438.3 (l), Provider shall provide a Client the ability to choose the person providing services to them.

3. TIMELY ACCESS
A. Provider shall comply with the requirements set forth in Title 9, CCR, §1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of the need for services. County shall monitor Provider to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.
B. Timely access standards include:
I. Providers must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the Provider offers services to non-Medi-Cal clients. If the Provider's provider only serves Medi-Cal

clients, the provider must provide hours of operation comparable to the hours the Provider makes available for Medi-Cal services that are not covered by the Agreement or another county.

II. Appointment data, including wait times for requested services, must be recorded and tracked by Provider, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management department or other designated persons.

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

IV. Non-urgent non-psychiatry mental health services, including, but not limited to Assessment, Targeted Case Management, and Individual and Group Therapy appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 10 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service. Non-urgent psychiatry appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 15 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service

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

VI. Periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.

4. PRACTICE GUIDELINES

A. Provider shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements:

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

II. They consider the needs of the clients;

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

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

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

5. PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)

A. 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, pursuant to BHIN 20-071 requirements, the 21st Century Cures Act, and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.

B. SMHS licensed individuals required to enroll via the "Ordering, Referring and Prescribing" (ORP) PAVE enrollment pathway (i.e., PAVE application package) available through the

DHCS PED Pave Portal, include: Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC), Psychologist, Licensed Educational Psychologist, Physician (MD and DO), Physician Assistant, Registered Pharmacist/Pharmacist, Certified Pediatric/Family Nurse Practitioner, Nurse Practitioner, Occupational Therapist, and Speech-Language Pathologist.

C. Interns, trainees, and associates are not eligible for enrollment.

6. PHYSICIAN INCENTIVE PLAN

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

7. REPORTING UNUSUAL OCCURRENCES

A. Provider shall report unusual occurrences to the Director. 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;

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 the Provider will cooperate in the conduct of such independent investigations.

ARTICLE 9. 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 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 claimed services.

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.

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 El Dorado County Behavioral Health Division 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).
   I. 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 upon reasonable notice.
   II. Provider shall document that costs are reasonable and allowable, and directly or indirectly related to the services provided hereunder.
   III. This report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.
   IV. Provider shall provide a copy of any Audit to County within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, as applicable.

C. **Provider shall provide copies of financial reports to the County on an annual basis during the term of this Agreement, within 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: 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 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. 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 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.

5. 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.

6. 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 C.F.R. § 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 C.F.R. § 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 Director. The Director 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.

ARTICLE 10. ADDITIONAL FINAL RULE PROVISIONS

1. NON-DISCRIMINATION
   A. Provider shall not discriminate against Medi-Cal eligible individuals in its County who require an assessment or meet medical necessity criteria for SMHS services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and State law.
   B. Provider shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.
   C. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
   D. 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, medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (Title 2, CCR, Sections 11100 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; and Title VI of the Civil Rights Act of 1964, as amended, the California Family Rights Act (Government Code Section 12945.2), the Unruh Civil Rights Act (California Civil Code, Division I, Part 2, Section 51, et seq), the Ralph Civil Rights Act (California Civil Code, Division I, Part 2, Section 51.7), the California Trafficking Victims Protection Act (California Civil Code, Division I, Part 2, Section 52.5), the Disabled Persons Act (California Civil Code, Division I, Part 2.5), and as applicable, Section 11135 et. seq., of the California Government Code, prohibiting discrimination in all state-funded programs. Provider and its employees and

representatives shall give written notice of their obligations under this clause as required by law.

E. 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.
F. Provider's signature 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, CCR, Section 11102.
G. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
H. Provider shall comply with Exhibit F, 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 F upon request by County.

2. PHYSICAL ACCESSIBILITY

In accordance with the accessibility requirements of section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973, Provider must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities.

3. 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 beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.
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 SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (Title 9, CCR, § 1810.365(c)).
D. The 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 C.F.R. § 438.106.

4. CULTURAL COMPETENCE

All services, policies and procedures must be culturally and linguistically appropriate. Provider must 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.

5. CLIENT INFORMING MATERIALS
   A. Basic Information Requirements
      I. Provider shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. §438.10(c)(1)). Provider shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Provider shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.
      II. Provider shall provide the required information in this section to each client receiving SMHS under this Agreement and upon request. (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26., attachments 3, 4; Tit. 9, CCR, § 1810.360(e).)
      III. Provider shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. §438.10.
      IV. Provider shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).
      V. Client information required in this section may only be provided electronically by the Provider if all of the following conditions are met:
         a. The format is readily accessible;
         b. The information is placed in a location on the Provider's website that is prominent and readily accessible;
         c. The information is provided in an electronic form which can be electronically retained and printed;
         d. The information is consistent with the content and language requirements of this Agreement;
         e. The client is informed that the information is available in paper form without charge upon request and the Provider provides it upon request within five business days. (42 C.F.R. § 438.10(c)(6)).
   B. Language and Format
      I. Provider shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii).)
      II. Provider shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.
      III. Provider shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Provider's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. § 438.10(d)(3).)
         a. Provider shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions Code § 14727(a)(1); Title 9, CCR, § 1810.410, subd. (e), para. (4))
      IV. Provider shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)-(4).)

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

VI. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

C. Beneficiary Informing Materials

I. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:
   a. Guide to Medi-Cal Mental Health Services
   b. County Beneficiary Handbook (BHIN 22-060)
   c. Provider Directory
   d. Advance Health Care Directive Form (required for adult clients only)
   e. Notice of Language Assistance Services available upon request at no cost to the client
   f. Language Taglines
   g. Grievance/Appeal Process and Form
   h. Notice of Privacy Practices
   i. Early & Periodic Screening, Diagnostic and Treatment (EPSDT) poster (if serving clients under the age of 21)

II. Provider shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.

III. Provider shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.

IV. Required informing materials must be electronically available on the Provider's website and must be physically available at the Provider agency facility lobby for clients' access.

V. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.

VI. Informing materials will be considered provided to the client if Provider does one or more of the following:
   a. Mails a printed copy of the information to the client's mailing address before the client first receives a SMHS;
   b. Mails a printed copy of the information upon the client's request to the client's mailing address;
   c. Provides the information by email after obtaining the client's agreement to receive the information by email;
   d. Posts the information on the Provider's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,

e. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Provider provides informing materials in person, when the client first receives SMHS, the date and method of delivery shall be documented in the client's file.

D. Provider Directory
   I. Provider must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.
   II. Provider must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).
   III. Any changes to information published in the provider directory must be reported to the County within two (2) weeks of the change.
   IV. Provider will only need to report changes/updates to the provider directory for licensed, waivered, or registered mental health providers.

ARTICLE 11. DATA, PRIVACY AND SECURITY REQUIREMENTS

1. CONFIDENTIALITY AND SECURE COMMUNICATIONS
   A. Provider shall comply with all applicable Federal and State laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII) including, but not limited to, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the California Welfare and Institutions Code regarding confidentiality of client information and records and all relevant County policies and procedures.
   B. Provider will comply with all County policies and procedures related to confidentiality, privacy, and secure communications.
   C. Provider shall have all employees acknowledge an Oath of Confidentiality mirroring that of County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.
   D. Provider shall not use or disclose PHI or PII other than as permitted or required by law.

2. ELECTRONIC PRIVACY AND SECURITY
   A. Provider shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. Provider's email transmissions shall display a warning banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.
   B. Provider shall institute compliant password management policies and procedures, which shall include but are not limited to procedures for creating, changing, and safeguarding passwords. Provider shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.
   C. Any Electronic Health Records (EHRs) maintained by Provider that contain any PHI or PII for clients served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Provider that utilize an EHR shall maintain all parts

of the clinical record that are not stored in the EHR, including but not limited to the following examples of client signed documents: discharge plans, informing materials, and health questionnaire.

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

3. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE BUSINESS ASSOCIATE AGREEMENT (BAA)
   A. Provider may perform or assist County in the performance of certain health care administrative duties that involve the use and/or disclosure of client identifying information as defined by HIPAA. For these duties, the Provider shall be a Business Associate of the County and shall comply with the applicable provisions set forth in Exhibit G, marked "HIPAA Business Associate Agreement," incorporated herein and made by reference a part hereof.
   B. Provider shall follow all requirements listed within the BAA and shall comply with all applicable County policies, state laws and regulations and federal laws pertaining to breaches of confidentiality. Provider agrees to hold the County harmless for any breaches or violations.

ARTICLE 12. CLIENT (ALSO REFERRED TO AS BENEFICIARY) RIGHTS

1. Provider shall take all appropriate steps to fully protect Clients' rights, as specified in Welfare and Institutions Code § 5325 et seq; Title 9, CCR, §§ 862, 883, 884; Title 22 CCR, §72453 and § 72527; and 42 C.F.R. §438.100.
2. Problem Resolution: Provider shall ensure that each Client is aware of and has access to the County's Problem Resolution process.
3. Provider shall comply with County written policies regarding the beneficiary rights, applicable laws and regulations relating to patients' rights, including but not limited to WIC 5325; CCR, Title 9, Sections 862 through 868; and 42 CFR Section 438.100. Should the Provider receive approval to subcontract in accordance with ARTICLE 2, General Provisions, 9. Assignment and Delegation. Provider shall ensure that its subcontractors comply with all applicable patient's rights laws and regulations; including the right to:
   I. Receive information in accordance with 42 CFR 438.10 (42 CFR Section 438.100(b)(2)(i));
   II. Be treated with respect and with due consideration for his or her dignity and privacy (42 CFR Section 438.100(b)(2)(ii));
   III. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand (42 CFR Section 438.100(b)(2)(iii))
   IV. Participate in decisions regarding his or her health care, including the right to refuse treatment (42 CFR Section 438.100(b)(2)(iv));
   V. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 CFR Section 438.100(b)(2)(v));
   VI. Request and receive a copy of his or her medical records, and to request that they be amended or corrected. (42 CFR Section 438.100(b)(2)(vi); 45 CFR Sections 164.524-164.526));
   VII. Be furnished services in accordance with 42 CFR Sections 438.206 through 438.210 (42 CFR Section 438.100(b)(3));

VIII. Freely exercise his or her rights without adversely affecting the way the Provider, treats the beneficiary (42 CFR Section 438.100(c)).

4. Choice of Provider**:** Provider shall provide a beneficiary's choice of the person providing services to the extent possible and appropriate consistent with CCR Title 9, Section 1830.225, and 42 CFR part 438.3(I).

ARTICLE 13. RIGHT TO MONITOR

1. County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of Provider in the delivery of services provided under this Agreement. Full cooperation shall be given by the Provider in any auditing or monitoring conducted, according to this Agreement.
2. Provider shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date of the Agreement period or in the event the Provider has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(I)-(ii)).
3. The County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Provider at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Provider's place of business, premises or physical facilities (42 CFR § 438.230(c)(3)(iv)).
4. Provider shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the County may audit, monitor, and/or request information from the Provider to ensure compliance with laws, regulations, and requirements, as applicable.
5. County reserves the right to place Provider on probationary status, should Provider fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Provider may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.
6. Provider shall retain all records and documents originated or prepared pursuant to Provider's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years from the term end date of this Agreement

or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Provider's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.

7. Provider shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.
8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
9. Provider shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.
10. Provider shall comply with ARTICLE 11. Data, Privacy And Security Requirements, regarding relinquishing or maintaining medical records.
11. Provider shall agree to maintain and retain all appropriate service and financial records for a period of at least 10 years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
12. Provider shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
13. In the event the Agreement is terminated, ends its designated term or Provider ceases operation of its business, Provider shall deliver or make available to County all financial records that may have been accumulated by Provider or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.
14. Provider shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Provider.
15. County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Provider has not performed satisfactorily.

ARTICLE 14. SITE INSPECTION

Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Provider shall permit authorized County, state, and/or federal agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Provider shall provide all reasonable assistance for the safety and convenience

of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

ARTICLE 15. 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 16. 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 17. 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 18. ENTIRE AGREEMENT

This Agreement, including all schedules, addenda, exhibits and attachments, contains the entire understanding of the Parties in regard to Provider's provision of the services specified in Exhibit A ("Scope of Work") and supersedes all prior representations in regard to the same subject matter, whether written or oral.

Requesting Contract Administrator Concurrence:

By: _____ Dated: _____

Name
Title
Department

Requesting Department Head Concurrence:

By: _____ Dated: _____

Name
Title
Department

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: _____ Dated: _____
Deputy Clerk

-- PROVIDER NAME--

By: _____ Dated: _____
Name
Title
"Provider"

By: _____ Dated: _____
Corporate Secretary