NAPA COUNTY AGREEMENT NO. 200105B
AMENDMENT NO. 1

THIS AMENDMENT NO. 1 TO AGREEMENT NO. 200105B is effective as of the 1st day of July, 2022, by and between **NAPA COUNTY**, a political subdivision of the State of California, referred to as "COUNTY" and **STANFORD YOUTH SOLUTIONS dba STANFORD SIERRA YOUTH & FAMILIES**, whose mailing address is 8912 Volunteer Lane, Sacramento, CA 95826, hereinafter referred to as CONTRACTOR." COUNTY and CONTRACTOR may be referred to below collectively as "Parties" and individually as "Party."

RECITALS

WHEREAS, on or about June 8, 2021, COUNTY and CONTRACTOR entered into Napa County Agreement No. 200105B (hereinafter referred to as the "Agreement") for CONTRACTOR to provide delivery of specialty mental health services in schools and in the community; and

WHEREAS, as of the effective date of this Amendment No. 2, the Parties wish to replace Exhibit A with Exhibit A-1 (Scope of Work) and Exhibit B with Exhibit B-1 (Compensation and Financial Reporting), to include the implementation of Therapeutic Behavioral Services (TBS) as well as increase the contract maximum to include higher rates.

TERMS

NOW, THEREFORE, for good and valuable consideration, the adequacy and receipt of which are hereby acknowledged, the Parties hereby amend the Agreement as follows:

1. The maximum amount of payment on Page 1 of the Agreement shall be **ONE MILLION ONE HUNDRED THOUSAND DOLLARS ($1,100,000.00)**, of which **Seven Hundred Forty Six Thousand Ninety Dollars ($746,090.00)** is increased by virtue of this Amendment No. 1; provided however, that such amounts shall not be construed as guaranteed sums, and compensation shall be based upon services actually rendered and expenses actually incurred.

2. Exhibit A is hereby replaced with "Exhibit A-1" attached hereto and incorporated by reference as set forth herein, and all references in the Agreement to Exhibit "A" shall refer to "Exhibit A-1" commencing as of the effective date of this Amendment No. 1.

3. Exhibit B is hereby replaced with "Exhibit B-1" attached hereto and incorporated by reference as set forth herein, and all references in the Agreement to Exhibit "B" shall refer to "Exhibit B-1" commencing as of the effective date of this Amendment No. 1.

4. Except as provided above, the terms and conditions of the Agreement shall remain full force and effect as originally approved.

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment No. 1 to Napa County Agreement No. 200105B as of the date first written above.

STANFORD YOUTH SOLUTIONS dba
STANFORD SIERRA YOUTH & FAMILIES

By _____
LAURA HEINTZ
Chief Executive Officer

By _____
JOVINA NEVES
Chief Financial Officer

"CONTRACTOR"

NAPA COUNTY, a political subdivision of the State of California

By: _____
RYAN GREGORY
Chair of the Board of Supervisors

"COUNTY"

APPROVED AS TO FORM Office of County Counsel By: *Rachel L. Ross* (e-signature) Date: May 26, 2022	APPROVED BY THE NAPA COUNTY BOARD OF SUPERVISORS Date: _____ Processed By: _____ Deputy Clerk of the Board	ATTEST: NEHA HOSKINS Clerk of the Board of Supervisors By:_____

EXHIBIT A-1

SCOPE OF WORK

July 1, 2022 through June 30, 2023
(and each subsequent year thereafter)

Introduction

As an organizational provider agency, CONTRACTOR shall provide administrative and direct Early Prevention, Screening, Detection and Treatment (EPSDT) program services to COUNTY'S Medi-Cal clients as defined in Title 9, Division 1, Chapter 11 of the California Code of Regulations (hereinafter "CCR"). CONTRACTOR may provide services to Napa County Medi-Cal eligible youth referred to CONTRACTOR by COUNTY Mental Health, or referred by schools that have received prior approval from COUNTY Mental Health. CONTRACTOR shall also provide supplemental specialty mental health services (hereinafter referred to as Therapeutic Behavioral Services ["TBS"]), specialty mental health services (hereinafter referred to as Intensive Care Coordination [ICC], and Intensive Home-Based Services [IHBS]) to COUNTY's individuals receiving Medi-Cal in the CONTRACTOR's program and locations as described herein. CONTRACTOR shall create and maintain sufficient documentation, as specified herein, to substantiate its claims for contract services authorized and actually provided.

Program Description:

Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") Supplemental Specialty Mental Health Services mean those services defined in CCR Title 22, Chapter 11, Section 51184.

EPSDT, IHBS, ICC, and TBS service delivery may be provided by co-location at a NCOE program site in order to better meet the needs of eligible students. Services may also be provided in other community, home, or clinical settings as deemed appropriate by COUNTY.

EPSDT services, when offered under this contract, are fully governed by its provisions and limitations, as described herein.

Service Definitions:

Assessment means a service activity which may include a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

Collateral means a service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity. Significant Support Person means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parent(s) or legal guardian(s) of the beneficiary who is a minor, the legal representative of the beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

Plan Development means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.

Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Rehabilitation is a service activity that includes assistance in improving, maintaining, or restoring an individual's or group of individuals' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, support resources, and/or medication education.

Targeted Case Management means service activities related to locating, coordinating and monitoring necessary and appropriate services for a beneficiary related to the beneficiary's treatment. Targeted Case Management services must be provided in close coordination with other service providers to ensure each provider is focusing their work on a specific aspect of each individual's goals and/or objectives. COUNTY will not authorize CONTRACTOR to provide Targeted Case Management Services if the beneficiary is already receiving Napa County Mental Health Plan services from another Napa County Mental Health Plan provider. Additionally, CONTRACTOR will inquire of each individual served whether or not other service providers are assisting the beneficiary with the goals/objectives identified on their mental health treatment plan. If the individual being served confirms this as fact, CONTRACTOR shall contact other providers to ensure that CONTRACTOR is not duplicating other providers' efforts. If another provider confirms that it is providing similar assistance to help the individual with the same objective(s), then CONTRACTOR shall not provide Targeted Case Management services to the individual that target those objective(s).

Intensive Care Coordination (ICC) is a Case Management service for children whom the MHP (Mental Health Plan, hereinafter referred to as MHP) certifies as being Katie A. Subclass members. ICC is a case management service that facilitates implementation of the cross-system/multi agency collaborative services approach described in the Core Practice Model (CPM). ICC is a case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of Katie A. Subclass. While the key service components of ICC are similar to Targeted Case Management (TCM), ICC differs in that it is integrated into the Child Family Team process to ensure that the needs of the child/youth in the Katie A. Subclass are appropriately and effectively met. The ICC services for the purpose of this contract is limited to participation in the Child Family Team meetings in order to share information on the provision and progress of IHBS or TBS being provided to a child/youth and family/caretakers, and with this information, to help in the planning for further services as needed to help the child/youth meet agreed upon goals.

Intensive Home-Based Services (IHBS) (following Individual Service Authorization by Napa County Mental Health) IHBS are intensive, individualized, strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons to help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services. The difference between IHBS and more traditional outpatient Specialty Mental Health Services (SMHS) is that IHBS is expected to be of significant intensity to address the intensive mental health needs of the child/youth, consistent with the plan, and predominantly delivered outside an office setting and in the home, school or community.

Therapeutic Behavioral Services (TBS) means services for County-authorized children and youth with serious emotional problems who are experiencing a stressful transition or life crisis and who need additional specific short term support to prevent placement in a psychiatric hospital, a group home at Rate Classification Level (RCL) 12 through 14, or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care. Service activities may include: assessment, plan development, collateral and TBS 1:1 coaching.

TBS 1:1 Coaching means individualized one-to-one behavioral assistance and one-to-one interventions to accomplish outcomes specified in the written TBS treatment plan provided by a qualified staff person on-site and immediately available to intervene for a specified period of time.

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Consistent with Medi-Cal SMHS regulatory requirements and the ICC, IHBS includes, but is not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the child/youth's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the child/youth to fully participate in the CFT and service plans including but not limited to the plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the child/youth and/or his or her family or caregiver(s) about, and how to manage the child/youth's mental health disorder or symptoms;
- Support of the development, maintenance, and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a child/youth's success in achieving educational objectives in an academic program in the community; and
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

<u>Intensive Care Coordination (following Individual Service Authorization by Napa County Mental Health)</u> Intensive Care Coordination (ICC) – a service that is responsible for facilitating assessment, care planning and coordination of services, including urgent services.

ICC is similar to the activities routinely provided as Targeted Case Management (TCM); ICC services must be delivered using a Community Family Team to develop and guide the planning and service delivery process. The difference between ICC and the more traditional TCM service

functions is that ICC must be used to facilitate implementation of the cross-system/multi-agency collaborative services approach for the Katie A. Subclass.

Although more than one mental health provider/practitioner may participate in the CFT, there must be an identified mental health ICC coordinator that ensures participation by the child or youth, family or caregiver and significant others so that the child/youth's assessment and plan addresses the child/youth's needs and strengths. CONTRACTOR must obtain pre-authorization to deliver and claim for ICC services.

Contact and Site Requirements for TBS, IHBS and ICC services

TBS 1:1 Coaching services shall be face-to-face with the child/adolescent individual and shall be provided in various home and community settings. Assessment, collateral, and rehabilitation services may be either face-to-face or by telephone with the child/adolescent individual or significant support persons and may be provided anywhere in the community. Plan development may be provided in absence of face-to-face or telephone contact with the individual or significant support person, however, must always include participation of the individual and significant support person. Contractor shall provide TBS services to Napa County children/youth placed in homes or foster placements within a serviceable radius. This also applies to the provision of IHBS and ICC services.

By definition, ICC may be provided to children/youth living and receiving services in the community (including Therapeutic Foster Care (TFC) as well as to children/youth who are currently in the hospital, group home, or other congregate or institutional placement. When ICC is provided in a hospital, psychiatric health facility, community treatment facility, group home or psychiatric nursing facility, it may be used solely for the purpose of coordinating placement of the child/youth on discharge from those Facilities and may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

IHBS may be provided in any setting where the child/youth is naturally located, including the home (biological, foster or adoptive), schools, recreational settings, child care centers, and other community settings. IHBS are available wherever and whenever needed including weekends and evenings. IHBS are typically (but not only) provided by paraprofessionals under clinical supervision. IHBS may not be provided to children/youth in Group Homes. IHBS can be provided outside the Group Home setting to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits as part of a plan coordinated by a Child and Family Team.

Non-reimbursable Services for TBS and IHBS

The following services are not reimbursable under the terms of this agreement:

a) Academic educational services.

b) Vocational services which have as a purpose actual work or work training.

c) Recreation.

d) Socialization is not reimbursable if it consists of generalized group activities which do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

e) Transportation of an individual to a service is not reimbursable unless the travel is a component of a reimbursable service activity.

Additional Conditions Under Which TBS and IHBS Are Not Reimbursable

a) When the need for therapeutic behavioral services are solely:

   1) For the convenience of the family or other caregivers, physician, or teacher.

   2) To provide supervision of to assure compliance with terms and conditions of probation.

   3) To ensure the child/youth's physical safety or the safety of others, e.g., suicide watch, or

   4) To address conditions that are not part of the child/youth's mental health condition

b) For children/youth who can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day probably do not need these services.

c) For children/youth who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.

d) When the beneficiary is an inpatient of a hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program.

e) When the beneficiary is a resident of juvenile hall or another correctional facility

Referrals

Referrals for CONTRACTOR's services will be solicited from the COUNTY Mental Health Plan. CONTRACTOR will document all referrals in a Request for Services log, which shall meet all COUNTY requirements and be provided to COUNTY'S staff upon request. At minimum the CONTRACTOR's Request for Services logs shall include:

1) The name of beneficiary;

2) The date of request; and,

3) The initial disposition of the request

Admission:

CONTRACTOR will document all admissions in a Request for Services log, which shall meet all COUNTY requirements and be provided to COUNTY'S staff upon request. At minimum the CONTRACTOR's Request for Services logs shall include:

1) the name of beneficiary,

2) the date of request, and

3) the initial disposition of the request

Intake

CONTRACTOR is responsible for timely service delivery following clients' initial request for service. Initial assessment service(s) must be provided within COUNTY'S required timeliness standards. Individuals who meet both medical necessity and funding criteria following assessment must be provided specialty mental health services of a type and amount needed to meet their individualized needs.

Individuals who do not meet the clinical and funding criteria for this program but screen as mild or moderate for mental health needs will be referred to Beacon for mental health services. CONTRACTOR shall clearly document in client's clinical record reasons why client does not meet medical necessity for specialty mental health services.

Notices of Action

CONTRACTOR shall follow COUNTY MHP timeliness standards for service delivery following request for services. Individuals who are not seen within these standards shall be issued a Notice of Adverse Benefit Determination (NOABD). Completed NOABD forms must be submitted to COUNTY MHP's Quality Coordinator within 2 business days from date of issue. In addition, If CONTRACTOR cannot serve the individual within the COUNTY MHP timeliness standards for service delivery, CONTRACTOR will refer individual to COUNTY for mental health services.

Client Information Requirements

All individuals seen under this Agreement shall be provided with informational materials as required by State and Federal Health Care regulations. CONTRACTOR shall coordinate with COUNTY staff to ensure that each individual being provided specialty mental health services

shall receive the materials listed below. If CONTRACTOR is responsible for providing intake into COUNTY Mental Health Plan services, CONTRACTOR shall maintain written verification that materials were distributed and/or completed for each client receiving services. Materials shall be provided at the intervals specified below and documentation shall include at minimum: the exact materials provided, the name of the individual receiving the materials, the date the materials were provided, and the name of the staff member providing these materials.

1. Informational Materials To Be Provided At Intake:

    a) The Napa County Guide to Medi-Cal Mental Health Services (MHP Beneficiary Brochure).

    b) The Napa County Provider Directory.

    c) HIPAA Notice of Privacy Rights (and signed Acknowledgement of Receipt of Notice of Privacy Rights).

    d) Information Sheet on TBS Services.

    e) Admission Agreement & Consent to Treatment Form.

    f) Authorization for Release of Information to appropriate parties including Napa County Mental Health providers.

    g) Psychotropic Medication Informed Consent upon initiation of treatment with such medications.

2. Informational Materials To Be Provided Annually, At Time Of Client Plan Renewal:

    a) The Napa County Guide to Medi-Cal Services (MHP Beneficiary Brochure).

    b) The Napa County Provider Directory.

    c) Admission Agreement & Consent to Treatment Form.

    d) Authorization for Release of Information to appropriate parties (as necessary).

3. In addition to the Informing Materials listed above, CONTRACTOR shall provide COUNTY with the following information:

    a) Organizational Provider Notification of Intake, Transfer, or Discharge form (at intake, staff transfer, and discharge).

    b) Demographic Information form.

    c) Diagnosis Review form.

Client Grievance Requirements

CONTRACTOR shall comply with COUNTY's client grievance requirements and ensure that the following procedures are followed:

a) Make readily available to clients, the Napa County HHSA Mental Health Grievance forms along with postage paid addressed envelopes; and post information regarding COUNTY's client problem resolution process.

b) When an individual expresses a concern regarding CONTRACTOR'S services, CONTRACTOR shall determine the nature of the concern and, if the concern is easily fixed or poses a risk to others, it should be immediately resolved.

c) For all grievances, provide the individual with the Mental Health Grievance Form for Medi-Cal Eligible Beneficiaries (Grievance Form) and direct them to fill it out and return it to COUNTY's Mental Health Quality Coordinator in the postage paid envelope. CONTRACTOR is responsible for completing the Grievance form for oral grievances received.

d) Provide beneficiaries with reasonable assistance in completing forms and taking procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

e) Notify COUNTY's Mental Health Quality Coordinator within 24 hours of the next business day via fax or phone that a grievance has been made and provide the details of the grievance. Provide the individual's name, the date and time that the grievance was made, CONTRACTOR's name, a brief description of the concern, and any steps taken to resolve the matter.

Allowable Service Activities

Services to be provided by CONTRACTOR as authorized by COUNTY under this Agreement shall include the following specialty mental health services:

1. Assessment
2. Collateral
3. Individual therapy
4. Family therapy
5. Group Therapy
6. Rehabilitation—Individual
7. Rehabilitation--Group

8. Plan Development
9. Targeted Case Management
10. Intensive Care Coordination (with prior COUNTY authorization)
11. Intensive Home Based Services (with prior COUNTY authorization)
12. Therapeutic Behavioral Services

Allowable Service Activity Coding

CONTRACTOR shall ensure that all services are correctly coded using the codes provided below:

TABLE 1: MENTAL HEALTH SERVICES

Activity Description	**Code**
Assessment-not face to face with client	9
Assessment	10
Plan Development	13
Therapy Individual	30
Group Therapy	31
Family Therapy	32
Collateral	33
Mental Health Rehabilitation --Individual	34
Mental Health Rehabilitation -- Group	35
Targeted Case Management	50
Intensive Care Coordination	110
Intensive Home-Based Services	111
TBS Assessment	801
TBS Collateral	816
TBS Plan Development	818
TBS 1:1 Coaching	819

Staffing Requirements – General

a) Mental Health Therapy Services and Mental Health Assessment with Diagnosis Services shall be provided by a Physician, Psychologist, Licensed Clinical Social Worker, Marriage and Family Therapist, Marriage and Family Therapist- Intern, (MFTI), or an Associate Clinical Social Worker (ASW), but may also be provided by a graduate trainee in an approved graduate program of study, so long as each clinical service is delivered under a Licensed Practitioner of the Healing Arts, and each clinical document is co-signed by an LPHA. LPHA's include Educational Psychologists, Psychologists, Marriage and Family Therapists, Licensed Clinical Social Workers, and Psychiatrists.

b) Other specialty mental health services may be provided by any person determined by COUNTY to be qualified to provide the service, consistent with state law.

c) Medi-Cal mental health services provided to Spanish speaking clients shall be provided by qualified bilingual and bicultural staff whenever possible.

Non-reimbursable Services

The following services are not reimbursable under the terms of this Agreement:

f) Academic educational services

g) Vocational services which have as a purpose actual work or work training

h) Recreation

i) Socialization is not reimbursable if it consists of generalized group activities which do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

j) Transportation of a client to a service is not reimbursable unless the travel is a component of a reimbursable service activity.

Lockouts

CONTRACTOR may provide and document services under the following situations, however those services are not reimbursable as the setting the client resides in or the type and amount of service is non-reimbursable through Medi-Cal. Lockouts include the following:

a) Mental Health Services provided during the time a client is a resident of juvenile hall or another correctional facility.

b) Mental Health Services provided during the time a client is residing in a Crisis Residential Treatment program except on the day of admission.

c) Mental Health Services provided during the time a client is residing in an acute inpatient psychiatric hospital

d) All Mental Health Services during the time an individual is a resident in a federally defined Institution for Mental Disease (IMD).

An exception to this lockout of reimbursable services is the first day of commitment in an acute care inpatient setting.

Medical Necessity Criteria for Children and Youth

CONTRACTOR shall only seek Medi-Cal reimbursement for mental health services when the beneficiary being served meets the medical necessity requirements described herein, pursuant to Welfare and Institutions Code section 14184.402(a). 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.

For beneficiaries 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. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services (CMS) makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus medically necessary and covered as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

PROCEDURES:

A. Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, the MHP will 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 beneficiaries who meet **either of the following** criteria, (1) or (2) below:

1. The beneficiary 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 the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

2. The beneficiary meets **both of the following** requirements in a) and b), below:
    a. The beneficiary has **at least one** of the following:
        i. A significant impairment;
        ii. A reasonable probability of significant deterioration in an important area of life functioning;
        iii. A reasonable probability of not progressing developmentally as appropriate; or,
        iv. A need for SMHS, regardless of presence of impairment, which are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide;

AND

    b. The beneficiary's condition as described in subparagraph (2) above is due to **one of the following**:
        i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD;
        ii. A suspected mental health disorder that has not yet been diagnosed; or,
        iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

B. Additional Coverage Requirements and Clarifications

This criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

1. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
3. The beneficiary has a co-occurring substance use disorder.

Per Welfare and Institutions Code section 14184.402(f)(1)(A), 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 CMS approved ICD-10 diagnosis code.

Documentation Requirements for Services

Assessments: CONTRACTOR shall ensure that all client Medical Records include an assessment of each client's need for mental health services. The Comprehensive Assessment shall be completed by 30 days from the first intake session. While a clinician may choose to complete the Comprehensive Assessment up to thirty days from the first date of contact, per DHCS regulation, a determination of medical necessity (including the expanded EPSDT definition of medical necessity) should be made within the COUNTY's timeliness standards.

Assessments shall contain, at minimum, the following information:

1. Identifying client information
2. Sources of information

3. Referral information and context
4. Presenting concerns, symptoms and objective impairments in behavior or functioning, and relevant conditions affecting the client's physical and mental health.
5. Relevant health care issues and medical history reported by the client.
6. Relevant conditions, events and situations affecting the client's physical and mental health.
7. Current risk factors associated with danger to self, others and/or property.
8. Past and present use of tobacco, alcohol and caffeine. Illicit drugs, prescribed drugs, and over the counter medications should also be included.
9. Mental health and psychiatric history including: previous treatment dates, providers, interventions and responses, sources of clinical data, relevant family history and results of lab tests and consultations reports.
10. For children and adolescents, prenatal and perinatal events as well as complete developmental history
11. Family history, composition, interactions, socioeconomic factors, strengths and resources
12. Occupational and/or school history, including social and academic functioning
13. Medications prescribed. Psychiatrists will include informed consent, dosages of each medication and date of initial prescription.
14. Client's report of allergies and adverse reactions to medications.
15. Legal history and status.
16. Relevant cultural issues and history.
17. A mental status exam.
18. A complete DSM5/ICD10 diagnosis review form that is consistent with the information included in the assessment. Changes to diagnoses may only be made by licensed clinicians.
19. Clinical observations and impression of mental status, functioning and service needs.
20. Client's strengths in achieving goals.
21. Treatment recommendations (including prognosis for clients receiving medication services).

Reassessment. A reassessment is to be completed no more than one year from the date of the first session. The Reassessment form is the tool for evaluating current problems, functioning, and progress and informs the review of the individual's plan.

Client Plans. CONTRACTOR shall ensure that a client plan for services shall be completed within 60 days of the date of intake into services and at a minimum annually. Client plans shall contain, at minimum, the following:

1. Specific observable and/or specific quantifiable goals;
2. Proposed types of interventions;
3. Proposed duration of interventions;
4. Staff Signature and Date;
5. Client (Parent or Guardian) Signature and Date.

Additional requirements for client plans:

1. Client plans shall be consistent with the diagnoses, the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of client's participation in and agreement with the plan. The client plan is to be, when possible, collaboratively constructed with the client and parents.
2. Examples of documentation include, but are not limited to, reference to the client's participation in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
3. When the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include written explanation of the refusal or unavailability. For clients who initially refuse to sign the client plan, the CONTRACTOR shall document ongoing efforts to secure documentation of client participation and agreement.
4. CONTRACTOR shall provide a copy of the client plan to client upon client's request and shall document that a copy was provided in the client record.

Progress Notes. CONTRACTOR shall ensure that all services provided are accurately and legibly documented in service or progress notes. A progress note is to be completed for every meaningful client contact, which includes but is not limited to individual therapy, family therapy, phone calls, relevant meetings, etc. Progress notes are to be completed in sufficiently timely manner to ensure continuity of care. Progress notes for each service shall contain, at minimum, the following information:

1. Client's name.
2. Client diagnosis code (billing diagnosis).
3. Mode of service identified by proper activity code.
4. Program code.
5. Date of service.
6. Start time of service.
7. Length of service: billable client time.
8. Length of service: staff time.
9. Name of clinician providing service.
10. Staff intervention and client response.
11. Documentation of any existing risk factors.
12. Signature of clinician providing service and date of signature.
13. Licensure and/or staff title of clinician providing service.

Level of Care Tool. A functional assessment tool may be required for every client who enters CONTRACTOR's outpatient therapy programs for purposes of determining program eligibility and level of care. If and at such time COUNTY adopts a specific instrument for use by its contractors, CONTRACTOR shall implement that tool within 60 days of receiving written notice, and administer said tool at the prescribed interval.

Closing Summary. A Closing Summary is to be completed at case closing. The purpose of the Closing Summary is to capture essential elements of treatment – referring problem, treatment conducted, response to treatment, and disposition.

CONTRACTOR shall provide COUNTY with access to all documentation of services provided under this Agreement for COUNTY'S use in administering this Agreement. Without limitation, COUNTY shall have access to such documentation for quality assurance and for audit or substantiation of claims for payment of services.

At a minimum, all documentation shall include accurate clinical and administrative records as required by law. Such records shall be legible, shall list each date of services, and include the total time for each service including documentation time. All services shall be documented

utilizing COUNTY-approved templates and contain all required elements as described herein. Activity codes shall be documented on each date of service using activity codes included herein. Upon written notice from the designated Contract Administrator, COUNTY, at its sole discretion, may impose additional requirements for documentation.

Electronic Medical Record and Billing Provision

As specified by COUNTY, CONTRACTOR shall update its clinical and fiscal practices at the COUNTY's request where change is necessary to ensure the following:

a) Correct billing of Medi-Cal services by COUNTY to Short-Doyle/Medi-Cal (SD/MC)

b) Congruence with COUNTY requirements for documentation, clinical or fiscal

c) Seamless integration with and use of the electronic medical record, the electronic billing system, and other relevant aspects of the Anasazi software system.

Additional costs incurred by CONTRACTOR shall be borne solely by CONTRACTOR.

COUNTY will provide relevant training and technical support to CONTRACTOR.

Audit Requirements

CONTRACTOR shall institute and conduct a Quality Assurance Process for all services provided under this Agreement. Said process shall include, at minimum, a system for verifying that all services provided and claimed for reimbursement meet specialty mental health service definitions and are documented accurately.

Upon request, CONTRACTOR shall provide COUNTY with documentation of CONTRACTOR's organizational capacity to conduct internal quality management activities, including chart audits. CONTRACTOR shall also provide documentation of the measures in place to assess key quality factors (including appropriateness, efficacy, and effectiveness) and key risks (including client safety and adherence to funding standards). At minimum, CONTRACTOR must conduct internal case record reviews at least quarterly. CONTRACTOR shall submit timely reports of these internal monitoring activities, as well as reports on quarterly incidents, accidents, and client complaints as requested by COUNTY

CONTRACTOR shall provide COUNTY with notification and a summary of any internal audit exceptions and the specific corrective actions taken to sufficiently reduce the errors that are

discovered through CONTRACTOR'S internal audit process CONTRACTOR shall provide this notification and summary to COUNTY in a timely manner.

CONTRACTOR shall reimburse COUNTY for all overpayments identified by CONTRACTOR, COUNTY, and/or State or Federal oversight agencies as an audit exception. CONTRACTOR shall make any repayment based on audit exception(s) upon discovery of said exception(s).

Program Reporting

CONTRACTOR staff will provide data to COUNTY monthly as follows:

1. Number of individuals requesting program services.
2. Number of individuals assessed for program services and disposition of each assessment,
3. Time from date of request for service to date of first service
4. Number of individuals referred out to Beacon for mental health services
5. Demographic and language needs of all individuals served by the program

Performance Standards

In evaluating client records COUNTY will evaluate services with reference to applicable contract, state, and federal standards for service delivery and documentation. Without limitation, HHSA will at a minimum evaluate services and documentation with reference to the standards set forth in the attached Service Descriptions standards in determining whether they qualify for payment under this Agreement. The Service Description standards and all other requirements contained in this Agreement shall set forth the minimum standards that CONTRACTOR shall meet and that COUNTY shall monitor.

In the event COUNTY revises the required standards in the course of the contract year, the revised standards shall be provided to CONTRACTOR, along with an explanation of the impact of any changes on CONTRACTOR, and CONTRACTOR shall be required to meet the revised standards. Failure to meet the revised standards within a reasonable time, as determined by COUNTY, shall be grounds for termination of this Agreement.

COUNTY and CONTRACTOR agree to work collaboratively to develop key service quality indicators and outcomes and identify sources of reliable data to measure them. In addition, attributes and characteristics of persons served and other necessary information shall also be identified collaboratively.

Orientation, Training and Technical Assistance

COUNTY will endeavor to provide CONTRACTOR with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement and (b) conduct the quality management activities called for by the Agreement.

COUNTY shall provide CONTRACTOR with all applicable standards for the delivery and accurate documentation of services. COUNTY shall make ongoing technical assistance available in the form of direct consultation to CONTRACTOR upon CONTRACTOR's request, to the extent that COUNTY has capacity and capability to provide this assistance. In so doing, COUNTY is not relieving CONTRACTOR of its independent duty to provide training and supervision to its staff, and to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement. Any requests for technical assistance by CONTRACTOR regarding any part of this Agreement shall be directed to the COUNTY's designated contract monitor.

EXHIBIT B-1
COMPENSATION

July 1, 2022 – June 30, 2023
(and each subsequent year thereafter)

1. All Specialty Mental Health Services performed at COUNTY pre-approved locations shall be administered, billed, and reviewed through CONTRACTOR's central fiscal office.

2. COUNTY shall compensate CONTRACTOR for contract services actually provided and documented, as defined in Table 1 in Exhibit A. Rates billed for contract services during the contract term shall be based on the lesser of CONTRACTOR's actual cost or at the following rates:

TABLE 1: MENTAL HEALTH SERVICES @ the rate of: $3.84/minute and Therapeutic Behavioral Services (TBS) @ $3.09/minute

Activity Description	Code
Assessment	10
Plan Development	13
Individual Therapy	30
Group Therapy	31
Family Therapy	32
Collateral	33
Individual Rehabilitation	34
Group Rehabilitation	35
Targeted Case Management	50
Intensive Care Coordination	110
Intensive Home-Based Services	111
Child & Family Team (CFT)	112
TBS Assessment	801
TBS Collateral	816
TBS Plan Development	818
TBS 1:1 Coaching	819

3. A billing unit is defined as one minute of service. Only authorized service activities provided by an eligible staff person providing a Medi-Cal eligible service to a Napa County Medi-Cal eligible client shall be reimbursed. The following requirements apply for claiming of services:

   a) The exact number of minutes that a reimbursable service was provided by program staff shall be reported and billed.
   b) In no case shall the units of time reported or claimed by one staff person exceed the hours worked.
   c) When a staff person provides service to, or on behalf of, more than one beneficiary at the same time, the staff person's time must be prorated to each

beneficiary. When more than one staff person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

d) All documentation of services provided to, or on behalf of, more than one beneficiary at the same time or services provided by multiple staff members to one or more beneficiaries at the same time must clearly indicate the clinical need for such a treatment approach.
e) All documentation of services provided to, or on behalf of, more than one beneficiary at the same time, or services provided by multiple staff members to one or more beneficiaries at the same time must clearly delineate the total minutes of the direct service, the total minutes of documentation and the total clients served.
f) The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.
g) Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time spent on plan development activities may be billed regardless of whether there is a face-to-face or phone contact with the beneficiary.

4. Total contract payments for the term shall not exceed the contract maximum, which is based on an estimate of services that may be performed during the contract period and shall not be considered a guaranteed sum.

5. Per Federal Regulation, providers must bill all other health coverage prior to submitting claims to Napa County for Medi-Cal reimbursement

The Other Health Care (OHC) insurer is considered the primary insurance and may pay all, part, or none of the cost of services. Any unreimbursed cost may be claimable to Medi-Cal. Claims where OHC exists must be submitted to Napa County within 30 days from receipt of the Explanation of Benefits (EOB), but no later than 5 months from the date of service. When submitting claims to Napa County for individuals with OHC, a copy of the OHC EOB or denial must be attached to the monthly itemized invoice.

In order to submit claims to Napa County within 5 months from the date of service, it is in the best interest of the client and CONTRACTOR to submit claims to the OHC insurer in a timely manner. If no response or EOB is received from the OHC insurer primary insurance within 90 days from the date of claim submission, CONTRACTOR may presume denial from the OHC and submit its monthly itemized invoice to Napa County. When submitting claims with a presumed denial from the OHC, CONTRACTOR shall attach a letter stating that no response was received from the OHC, include in the letter the name of the OHC, and the date the claim was submitted.

COUNTY makes every attempt to identify eligibility and notify CONTRACTOR if OHC eligibility exists. As eligibility verification for OHC can be inconsistent, it is also

imperative that CONTRACTOR inquire with the client/guardian as to possible OHC and notify COUNTY if OHC eligibility is discovered.

COUNTY is unable to provide a comprehensive list of procedures and points of contact for OHC insurers as they are numerous and have individual requirements. Therefore, CONTRACTOR is responsible for obtaining the necessary information to fulfill its duty to bill OHC insurers. As able, COUNTY will assist CONTRACTOR in finding contact information for OHC insurers but COUNTY is under no obligation to do so and this does not alleviate CONTRACTOR from the sole responsibility to do so.

6. Where OHC does not exist, CONTRACTOR shall submit monthly, itemized invoices to COUNTY's Mental Health Fiscal Analyst by the 15th of the month for all authorized contract services provided in the preceding month. The monthly invoice shall itemize, at a minimum, for each billed service the following information:
   - Client's name
   - Program name client is enrolled in
   - Description of service provided with identifiable activity code set forth in Exhibits 'A' and 'B,' Table 1.
   - Date of service
   - Length of service
   - Rate of service
   - Name of clinician providing service
   - Total amount billed for each service

   In the event of inconsistency between the foregoing requirements and those in the General Terms and Conditions, the foregoing requirements shall prevail.

7. Monthly invoice shall only include billing for the contract services actually performed in the manner described herein. Any questions related to billing may be directed to the Mental Health Fiscal Analyst at (707) 253-4662.

8. **Limitations Affecting Payments.** CONTRACTOR shall perform services and provide such documentation as required by all applicable State and Federal laws, rules, and regulations, and as described in Exhibit A of this Agreement. Other limitations affecting contract payments may include, but are not limited to:
   - CONTRACTOR shall provide such documentation as required by COUNTY at any time in order to substantiate its claims for payment. COUNTY may elect to withhold payment for failure by CONTRACTOR to provide such documentation required by COUNTY.
   - CONTRACTOR's services and claims are subject to any audits conducted by COUNTY, the State of California or federal government, or other auditors. Any resulting audit exemption shall be repaid to COUNTY.
   - CONTRACTOR shall make COUNTY whole for disallowances for payment or lost revenues as identified and discovered by COUNTY that are attributable to CONTRACTOR's performance under this Agreement, including, but not limited to, CONTRACTOR's insufficient documentation of Medical Necessity or billing errors by

CONTRACTOR that preclude COUNTY from claiming the Federal Financial Participation share of Medi-Cal.

- To the extent CONTRACTOR is required to make COUNTY whole under this Paragraph, COUNTY may elect to withhold any payments for past services, offset against any payments for future services for which CONTRACTOR provides, or demand reimbursement without offset.
- CONTRACTOR shall pay any penalty or fine assessed against COUNTY arising from CONTRACTOR's failure to comply with all applicable Federal or State Health Care Program Requirements, including, but not limited to any penalties and fines which may be assessed under a Federal or State False Claims Act provision.

9. CONTRACTOR shall submit an annual cost report due by August 31st following the end of the fiscal year. Failure to submit the cost report timely may result in the suspension of payments until the cost report is received by the COUNTY. Any funds received by CONTRACTOR in excess of actual costs reflected in the cost report shall be refunded to the COUNTY.

10. Non-compliance with the provisions of this Exhibit B-1 may lead at any time to withholding of payments and/or a termination of the Agreement based on breach of contract**.**