NAPA COUNTY AGREEMENT NO. 230135B
AMENDMENT NO. 4

THIS AMENDMENT NO. 4 TO AGREEMENT NO. 230135B is effective as of the 1st day of December 2024, by and between NAPA COUNTY, a political subdivision of the State of California, hereinafter referred to as "COUNTY" and **MENTIS, INC.**, a non-profit organization 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 July 1, 2022, COUNTY and CONTRACTOR entered into Napa County Agreement No. 230135B (hereinafter referred to as "Agreement") for CONTRACTOR to provide specialty mental health services for seriously mentally ill adults in a supportive permanent living environment; and

WHEREAS, on or about July 1, 2023, the Parties amended the Agreement to replace Exhibit A with Exhibit A-1 (Scope of Work), Exhibit B with Exhibit B-1 (Compensation), and incorporate an Exhibit D (Specialty Mental Health Services CalAIM and Payment Reform Contractor Boilerplate); and

WHEREAS, on or about July 1, 2023, the Parties amended the Agreement to increase to contract maximum, modify Section 3 – Specific Terms and Conditions 3.4, replace Exhibit B-1 with Exhibit B-2 (Compensation), and incorporate Exhibit E (Medi-Cal Base Rates and Incentives); and

WHEREAS, on or about July 1, 2024, the Parties amended the Agreement to replace Exhibit A-2 with Exhibit A-3 (Scope of Work), replace Exhibit B-2 with Exhibit B-3 (Compensation and Financial Reporting), and replace Exhibit E with Exhibit E-1 (Medi-Cal Outpatient Rates); and

WHEREAS, as of the effective date of this Amendment No. 4, the Parties wish to amend the Agreement to increase the contract maximum, replace Exhibit A-3 with Exhibit A-4 (Scope of Work), replace Exhibit B-3 with Exhibit B-4 (Compensation) in order to allocate Behavioral Health Bridge Housing (BHBH) grant funds to incoming residents of their new housing unit.

TERMS

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

1. The maximum amount of payment on Page 1 of the Agreement shall be **Two Hundred Fourteen Thousand Seven Hundred Forty-Two Dollars ($214,742.00),** for Fiscal Year 2024-2025 through Fiscal Year 2026-2027, of which **Fifty-Four Thousand Dollars ($54,000.00)** is increased by virtue of this Amendment No. 4; this amount will revert back to **One Hundred Sixty Seven Hundred Forty-Two Dollars ($160,742.00)** beginning Fiscal Year 2027-2028 and for each subsequent renewal thereafter; 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-3 is hereby replaced with "Exhibit A-4" attached hereto and incorporated by reference as set forth herein, and all references in the Agreement to Exhibit "A-3" shall refer to "Exhibit A-4" commencing as of the effective date of this Amendment No. 4.

3. Exhibit B-3 is hereby replaced with "Exhibit B-4" attached hereto and incorporated by reference as set forth herein, and all references in the Agreement to Exhibit "B-3" shall refer to "Exhibit B-4" commencing as of the effective date of this Amendment No. 4.

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

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment No. 4 to Napa County Agreement No. 230135B as of the first date written above.

MENTIS, INC.

By Rob Weiss
ROB WEISS, Executive Director

By _____
JULISSA MARCENCIA, Board Secretary

"CONTRACTOR"

NAPA COUNTY, a political subdivision of the State of California

By _____
JOELLE GALLAGHER
Chair of the Board of Supervisors

"COUNTY"

APPROVED AS TO FORM Office of County Counsel By: By: *Rachel L. Ross* (e-signature) Date: 11/19/2024	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-4
SCOPE OF WORK
December 1, 2024 through June 30, 2025
(and each subsequent automatic renewal)

Introduction

COUNTY's Health and Human Services Agency (HHSA) aims to provide specialty mental health services through the Supportive Living Program (SLP). These services are offered to Medi-Cal eligible individuals with serious mental illness. The program supports individuals who need assistance to live independently in either permanent or transitional housing.

A limited number of clients served under this contract may also qualify for Behavioral Health Bridge Housing (BHBH) rental assistance. Details regarding distinct eligibility and program requirements for BHBH funding are provided later in this exhibit. The BHBH program ends on June 30, 2027.

CONTRACTOR shall provide said services in CONTRACTOR'S separate programs as described herein; and locations as described herein.

SLP: Target Population

Individuals targeted for referral are those who:

1. are identified as having a major mental illness;
2. are verified as Medi-Cal eligible;
3. need behavioral health support in order to live in the community without 24-hour supervision;
4. wish to, and have some capacity, to live more independently; and
5. are able to self-administer medications (with support as needed).

Issues that have impacted these individuals' ability to live completely independent at this level include such things as: non-compliance with or resistance to medications, non-assaultive aggressiveness, psychotic ideation; hygiene deficiencies; and substance abuse histories, among other issues. The group of those individuals who will be served includes those who are discharged directly from higher levels of care as deemed appropriate through the SLP admission process.

SLP: Program Description

CONTRACTOR's Supportive Living Program (SLP) shall provide specialty mental health services to Medi-Cal eligible individuals or individuals in families with serious mental illness in Napa County who are unable to maintain independent housing placements in the community because of insufficient structure and mental health support in these placements—or who are placed in permanent housing but need support and supervision in these placements in order to

remain housed at this level of care. CONTRACTOR shall coordinate with other providers in the community to ensure qualified individuals receive necessary mental health services and supports as a component of their housing in CONTRACTOR's permanent housing project.

SLP: Program Requirements

Certification as an Organizational Provider: CONTRACTOR shall operate as, and meet all standards required of, an organizational provider defined and regulated in Title 9, Division 1, Chapter 11, California Code of Regulations (CCR). CONTRACTOR shall meet the MHP's certification process to include a site review in addition to a review of relevant documentation.

At minimum, COUNTY certification requires that CONTRACTOR meets the following standards:

1. Staff providing specialty mental health services shall possess the necessary license or certification to provide those services. CONTRACTOR certifies that all staff providing services hereunder are qualified to provide the service for which reimbursement is claimed, based upon education, experience and licensure. CONTRACTOR shall maintain records verifying said qualifications for each service provider providing services under this agreement, and documenting the provision of supervised hours as required by the Board of Behavioral Sciences for Marriage and Family Counselor- Interns, (MFTI), Licensed Professional Clinical Counselors-Interns (LPCC), or an Associate Clinical Social Workers (ASW). CONTRACTOR shall provide evidence of said records as requested by COUNTY. Maintain a safe facility. If staff providing services are not licensed or registered interns, CONTRACTOR shall provide evidence of specified qualifications as requested by COUNTY.
2. Maintain medical records in a manner that meets state and federal standards. All medical record requirements for Specialty Mental Health services shall be met and/or exceeded.
3. Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.
4. Possess the necessary license to operate.
5. Provide for appropriate supervision of staff.
6. Have as head of service a licensed mental health professional or other appropriate individual as described in Sections 622 through 630 of Title 9, Division 1, Chapter 3, of the California Code of Regulations.
7. Possess appropriate liability insurance.
8. Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to CCR Title 9, Division 1, Chapter 11, Section 1840.105.
9. As a condition for reimbursement, CONTRACTOR shall ensure beneficiaries shall receive the same level of services as provided all other clients served.
10. Inform the MHP of any sentinel event or occurrence in which COUNTY'S individual receiving services covered under this contract suffers physical injury, emotional trauma,

death or serious side-effect which could be attributed as caused in any way by CONTRACTOR. Such events shall be immediately reported to the Napa County Behavioral Health Director and/or his/her designee.

11. CONTRACTOR shall provide culturally and linguistically appropriate services to individuals as defined in the Napa County Specialty Behavioral Health Implementation Plan.
12. CONTRACTOR shall post Napa County Guide to Medi-Cal Services (MHP Beneficiary Brochure) in both public areas of housing unit and programmatic areas of agency.
13. CONTRACTOR shall post Napa County Grievance forms and self-addressed envelopes in both public areas of housing unit and programmatic areas of agency.

SLP: Services Provided

CONTRACTOR shall provide and document as specified herein for the specialty mental health services listed in the *Service Definitions* section below, and as authorized by COUNTY.

Upon acceptance of an individual, the CONTRACTOR'S SLP staff shall make a behavioral health assessment of the individual or family's needs, resources, strengths, and weaknesses, then develop a written service plan. The assessment and plan shall include documentation of all elements necessary to meet medical necessity criteria as set forth herein. The assessment and plan shall consider the individual's functioning abilities, as well as the individual's strengths and challenges in regard to housing, substance abuse counseling, behavioral health and/or peer support counseling, social linkages, educational activities, public benefits assessments and applications, vocational assessments, health services, nutritional counseling, living skills development and job or volunteer placement.

COUNTY may require CONTRACTOR to utilize a standardized Level of Care tool approved by COUNTY to document initial and ongoing client need for SLP level services. If COUNTY does not require a specific level of care tool CONTRACTOR may utilize any instrument that can accurately address a range of domains such as internalizing and externalizing behaviors and symptoms and allow for repeated administrations over the course of recurring CONTRACTOR's SLP visits and to allow SLP staff to gauge client's progress or lack of progress while receiving SLP services.

CONTRACTOR shall visit all clients at a minimum one time per week.

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.

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

Targeted Case Management means service activities related to locating, coordinating, and monitoring necessary and appropriate services for a beneficiary related to their 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 individual is already receiving Napa County Behavioral Health Plan services from another Napa County Behavioral Health Plan provider. Additionally, CONTRACTOR will inquire of each individual served whether or not other service providers are assisting the individual 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 they are not duplicating other provider's efforts. If other provider confirms that they are 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).

Rehabilitation is a service activity which 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, and support resources; and/or medication education.

Crisis Intervention Service, lasting less than 24 hours, to or on behalf of an individual for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral, and therapy. Note that billing for crisis intervention services is limited to 8 hours per instance.

Authorization and Reauthorization Requirements

COUNTY is responsible for authorizing and reauthorizing CONTRACTOR'S services consistent with Department of Health Care Services (DHCS) requirements specified in Napa County DHCS Contract. Authorization of ongoing services other than non-treatment assessment services shall be based on a comprehensive assessment that is due no later than *30 calendar* days from the date of intake, documented in COUNTY Access.

Admission

SLP referrals shall be solicited from various community agencies and from COUNTY. CONTRACTOR shall select individuals for the receipt of services in accordance with the criteria contained herein. COUNTY, at its discretion may require CONTRACTOR to direct all

individuals requesting CONTRACTOR's services to contact COUNTY's ACCESS program for assessment for behavioral health needs and referrals to any services that may address those needs.

CONTRACTOR shall be responsible for verifying Napa County Medi-Cal status and eligibility for individuals whose referrals originated from providers other than COUNTY.

For cases whom **COUNTY Access completes the initial comprehensive assessment** and refers to CONTRACTOR for ongoing services:

COUNTY ACCESS team will submit to CONTRACTOR:

The **Referral and Authorization Form**, indicating the services authorized and the authorization period, and the following clinical assessment documentation and informing materials.

1. Napa County Health and Human Services Demographic Form
2. Napa County Health and Human Services Behavioral Health Comprehensive Assessment
3. Napa County Health and Human Services Mental Status Exam
4. Napa County Health and Human Services Diagnosis Form
5. Napa County Health and Human Services Behavioral Health Division Admission Agreement and Consent for Treatment
6. Napa County Health and Human Services Agency Cost of Behavioral Health Services
7. Acknowledgement of Receipt of Notice of Privacy Practices
8. Napa County Health and Human Services Behavioral Health Services Interpretive Services Disclosure Form
9. Napa County Behavioral Health Access Registration Forms Checklist

CONTRACTOR will:

1. Accept COUNTY Access team initial comprehensive assessment and intake documentation and incorporate into the CONTRACTOR electronic health record.
2. Provide first face-to-face mental health service as soon as possible, but no later than *10 calendar days* from receipt of the referral.
3. Complete all required documentation, per Authorizations Guide, <u>as soon as possible</u> in order to initiate ongoing mental health services.
4. Close clients who do not engage. Those who engage beyond *60 calendar days* of date of NCMH initial assessment, CONTRACTOR will contact COUNTY Access for guidance.
5. Submit to NCMH Managed Care the ***Discharge Summary*** upon case closure.

For cases whom **CONTRACTOR completes the initial assessment**

CONTRACTOR will:

1. Offer first face-to-face initial screening appointment within ten *(10) calendar days* of request for service.
    a. The first request for service occurs when the individual and/or guardian initiates the request or agrees to the offer of service made by the CONTRACTOR.
2. Submit to COUNTY Access via **encrypted email** (MHAcess@countyofnapa.org) or Fax (707.259.8721) no later than ten *(10) calendar days* from starting the assessment process, the following forms:
    a. **Screening Tool**
    b. **Demographic Form** (to obtain the Napa County Medical Record number for that case).
    c. **Diagnosis Form** (Z03.89/No Diagnosis Code is permitted on this form at the screening stage)
3. Complete clinical assessment documentation and informing materials within thirty *(30) calendar days* of first face-to-face assessment appointment.
4. At the end of assessment, submit completed referral form to COUNTY Access Supervisor prior to presenting the client at a COUNTY Children's Authorization Review Team (CART) /Adults Authorization Review Team (AART) meeting.
5. For individuals who do not meet CONTRACTOR level of care:
    a. Inform the client/family of the determination and refer/collaborate with Carelon for services.
    b. If it is determined that client does not meet criteria for services, provide client/family with a ***Notice of Adverse Benefit Determination*** **(NOABD)**.

Informing Requirements

All individuals enrolling in CONTRACTOR's SLP program who are not, at the time of enrollment, already receiving Napa County Behavioral Health Plan services require receipt of special beneficiary informing materials as required by State and Federal Health Care regulations. CONTRACTOR shall coordinate with COUNTY staff to ensure that each individual meeting these criteria shall be provided the materials listed below. COUNTY and CONTRACTOR shall mutually agree which party will provide these materials to the individual being considered for enrollment. Should CONTRACTOR be determined responsible, CONTRACTOR shall maintain written verification that materials were distributed and/or completed for each individual 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.

Informing Materials To Be Provided At Intake

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

2. The Napa County Provider Directory
3. Information on Advance Health Care Directives
4. Napa County Admission Agreement & Consent to Treatment Form
5. Authorization for Release of Information to appropriate parties including Napa County Mental Health providers

In addition to the Informing Materials listed above, and if CONTRACTOR is deemed responsible, CONTRACTOR shall provide COUNTY with verification as requested that the following administrative paperwork has been provided to CONTRACTOR's individuals served on the schedule listed below:

a. Napa County Behavioral Health Demographic form – At intake, and updated annually
b. A Diagnosis Review Form signed and dated by a licensed practitioner, if not provided by COUNTY at Intake
c. HIPAA Privacy Rights and Acknowledgement of Receipt – At Intake
d. Client Financial Review form – At intake and updated annually

Referrals/Request for Service and Authorization Requirements

1. CONTRACTOR staff shall interview and assess all SLP candidates and shall obtain authorization from COUNTY prior to accepting individuals into the program. Authorization requests shall be reviewed and approved by COUNTY's Access/Managed Care staff.
2. CONTRACTOR shall maintain a Request for Services Log to document all CONTRACTOR referrals that are not made by COUNTY, which shall be presented to COUNTY'S staff for review upon request.

At minimum the CONTRACTOR's Request for Services logs shall include:

a. The name of beneficiary;
b. The date of request;
c. The date the assessment is offered (for siblings, Courage Center, and SOAR clients); and
d. The initial disposition of the request.

All services provided by CONTRACTOR and subject to reimbursement hereunder are defined in accordance with CCR Title 9, Division 1, Chapter 11.

Staffing Requirements – General

CONTRACTOR shall hire, train, and supervise staff to perform services under this agreement. CONTRACTOR'S staff members shall deliver services at CONTRACTOR'S housing program location or in other community housing sites. CONTRACTOR may also conduct other offsite activities with or for the benefit of program's participants in other community locations as necessary. Staff will provide services to individuals in their apartments in accordance with individuals' needs as determined through the assessment, level of care tool, and functional

evaluation process as set forth in the individual's service plan. Services may be provided seven days per week. Minimum client contact time is once per week. CONTRACTOR will provide 24-hour emergency telephone support.

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

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:

1. Academic educational services;
2. Vocational services which have as a purpose actual work or work training;
3. Recreation;
4. 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; and
5. Transportation of a client to a service is not reimbursable.

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:

1. For Medication Support Services: The maximum amount claimable for Medication Support Services in a 24 hour period is 4 hours.
2. Mental Health services provided during the time a client is a resident of juvenile hall or another correctional facility.
3. Mental Health Services provided during the time a client is residing in a Crisis Residential Treatment program except on the day of admission.
4. Mental Health Services provided during the time a client is residing in an acute inpatient psychiatric hospital.
5. 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 Adult Services

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.

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

Procedures

Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System:

For beneficiaries 21 years of age or older, CONTRACTOR shall provide covered specialty mental health services (SMHS) for beneficiaries who meet both of the following criteria, (1) and (2) below:

1. The beneficiary 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; and/or,
   b. A reasonable probability of significant deterioration in an important area of life functioning;

AND

2. The beneficiary's condition as described in paragraph (2) of the policy statement is due to either of the following:
   a. A diagnosed mental health disorder, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD); or,
   b. A suspected mental disorder that has not yet been diagnosed.

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.

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.

Discharge and Discharge Summary

Discharge from the program will occur, ideally, by mutual agreement between the individual and CONTRACTOR that the goals have been completed and the participant is able to live independently. Longitudinal Level of Care scores should also support this joint decision to discharge. Discharge may also occur by sole decision of the individual, or by sole decision of the CONTRACTOR. It is expected that all efforts to reach a mutually agreed-upon discharge plan will be put forth, but that there will be situations in which an individual chooses to leave the Program against the advice of the staff, or that the staff reach the conclusion that continuing to provide service to an individual would be against the best interests of the individual, would create a risk for other individuals, would impair their ability to benefit from the program, or would otherwise be detrimental to the program. CONTRACTOR preserves the right to discharge individuals from the program for cause and shall do so in accordance with all applicable federal and state regulations.

A Discharge Summary is to be completed at case closing. The purpose of the Discharge Summary is to capture essential elements of treatment – referring problem, treatment conducted, response to treatment, and disposition. Additionally, CONTRACTOR shall promptly inform

COUNTY that the individual is no longer enrolled in the SLP by submitting a Napa County Notification of Case Assignment, Termination, or Transfer form.

Documentation Requirements for Services

Assessments: CONTRACTOR shall ensure that all program participants' Medical Records include an assessment of each individual's need for mental health services. An Assessment shall be completed as soon as possible but within thirty (30) days of the first clinical service contact.

Assessments shall contain, at minimum, the following:

1. Identifying 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 behavioral health;
5. Relevant health care issues and medical history reported by the individual being served;
6. Relevant conditions, events and situations affecting the individual's physical and behavioral health;
7. Current risk factors associated with danger to self, others and/or property;
8. Past and present use of tobacco, alcohol and caffeine as well as illicit drugs prescribed and over the counter medications should also be included;
9. Behavioral 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. Individual'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 five-axis diagnosis consistent with the information gathered (Axis I and Axis II diagnoses, or changes to them, may only be made by licensed clinicians);
19. Clinical observations and impression of mental status, functioning and service needs;

20. Individual's strengths in achieving goals; and/or
21. Treatment recommendations (including prognosis for individuals receiving medication services).

Reassessment. The Reassessment is to be completed one (1) year from the date of the first session. The Reassessment form is the tool for evaluating current problems, functioning, and progress to drive the New Client Plan.

Individual Service Plans: CONTRACTOR shall ensure that an individual service plan shall be completed within sixty (60) days of the date of intake into services and at a minimum annually. Individual Service 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, License and/or Job Title, and Date
5. Individual's Signature and Date

Additional Requirements for Individual Service Plans:

1. Individual Service Plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the individual plan goals, and there shall be documentation of individual's participation in and agreement with the plan. The Individual Service Plan is to be collaboratively constructed with the individual.
2. Documentation of clients' agreement with the plan is best evidenced by inclusion of the client's signature and date of signature on the plan. In lieu of this signature CONTRACTOR shall reference to the individual's participation in the body of the plan or document the extent of the individual's participation and agreement in progress notes.
3. When the individual's signature is required on the Individual Service Plan and the individual refuses or is unavailable for signature, the Individual Service Plan or an individual progress note, shall include written explanation of the refusal or unavailability. Contractor shall document ongoing efforts to secure documentation of the individual's participation in, and agreement with their plan during the course of treatment.
4. The CONTRACTOR shall document that a copy of the Individual Service Plan was offered to the individual.

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 contact with the individual. Progress Notes are to be completed in a timely manner,

sufficient to ensure continuity of care. Progress Notes for each service shall contain, at minimum, the following information:

1. Individual's name and medical record number
2. Mode of service identified by proper activity code
3. Program (subunit) code
4. Date of service
5. Start time of direct service
6. End time of direct service
7. Total documentation time
8. Total travel time (if travel is component of mental health service activity)
9. Service indicators (person contacted, type of contact, place of service, appointment type, evidence-based practice/service strategy)
10. Name of clinician providing service
11. Narrative description of contact
12. Clinical decisions and interventions
13. Individual's response to interventions, including progress toward client plan goals
14. Documentation of any existing risk factors
15. Signature of clinician providing service, license and/or job title, and date of signature

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 the minimum, all documentation shall include accurate clinical and administrative records as required by law and policy. 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 designated Contract Administrator, COUNTY, at its sole discretion, may impose additional requirements for documentation.

Medi-Cal Service Documentation Requirements

A unit is defined as one minute of service. All authorized service activities provided by an eligible staff providing a Medi-Cal eligible service to a Napa County Medi-Cal eligible individual shall be recorded per minute.

The following requirements apply for Medi-Cal service documentation of services:

1. The exact number of minutes that a reimbursable service was provided by program staff shall be documented and reported.
2. In no case shall more than 60 units of time be reported or claimed for any one individual during a one-hour period.
3. In no case shall the units of time reported or claimed by one staff person exceed the hours worked.
4. When a staff person provides service to, or on behalf of, more than one individual at the same time, the staff person's time must be prorated to each individual. When more than one staff person provides a service to more than one individual 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.
5. All documentation of services provided to, or on behalf of, more than one individual 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.
6. All documentation of services provided to, or on behalf of, more than one individual at the same time, or services provided by multiple staff members to one or more individuals at the same time must clearly delineate the total minutes of the direct service, the total minutes of documentation and the total individuals served.

Program Performance Objectives

CONTRACTOR shall participate in the statewide performance outcome system that requires County Behavioral Health Departments and its contractor providers to administer consumer perception surveys to all individuals and their caregivers who are seen for services during a two (2) week reporting period semi-annually

Specific Performance Objectives During the Term of this Agreement.

1. Improved Independent Living skills:
   a. 75% of all individuals that enter and remain in the program for at least one (1) year will demonstrate improvement in their independent living skills as measured by completion of an independent living skills checklist assessment form at intake and re-evaluation on an annual basis.
2. Attainment of Personal Goals:
   a. 75% of individuals that enter and remain in the program for at least one (1) year will achieve a least one (1) of their personal goals as identified on their individual service plan-personal goals form completed at intake and re-evaluated on an annual basis.

Program Reporting

CONTRACTOR staff will provide program utilization review data to COUNTY upon request.

CONTRACTOR will conduct an annual client satisfaction survey to regularly assess client's satisfaction of services delivered. Contractor will report findings to COUNTY annually.

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 limiting this, HHSA will at a minimum evaluate services and documentation with reference to the standards set forth on the attached Service Descriptions standards in determining whether they qualify for payment under this agreement. This document and the 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 during the contract year, the revised standards shall be provided to the CONTRACTOR, along with an explanation of the impact of any changes on the CONTRACTOR.

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 information needed shall be identified.

CONTRACTOR shall provide COUNTY upon request, with documentation of CONTRACTOR's organizational capacity to conduct internal quality management activities, including chart audits. CONTRACTOR shall 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 shall be required to 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.

Contract Monitoring

COUNTY shall monitor CONTRACTOR's performance under this agreement to ensure the safety of individuals served, the appropriateness of services provided, their efficacy and effectiveness, and to protect against fiscal disallowances.

COUNTY shall designate its Provider Services Coordinator as the individual who shall monitor CONTRACTOR's performance under this agreement and serve as the primary point of contact regarding this agreement.

Monitoring Site Visits

This agreement contains provisions related to required objective service documentation standards, adherence to clinical standards of care, client satisfaction levels, client outcomes, authorization processes and invoicing. Without limiting those provisions, COUNTY shall have the right to conduct one or more site visits to the CONTRACTOR's place of business to monitor performance under this agreement. COUNTY will normally provide CONTRACTOR with thirty (30) days or more prior notice of such site visits.

This notice shall include:

1. The specific monitoring tool(s) that will be utilized;
2. The preparation required of the CONTRACTOR prior to the monitoring visit. HHSA may require the provision of specific information in writing prior to the site visit to expedite the monitoring activities; and
3. The information to be available for review at the time of the visit, which may include, among other things, individual service records, program policies and procedures, proof of licensure or certification, and documentation substantiating staff hours or other costs incurred by CONTRACTOR in providing the services being purchased.

As an outcome of the site visit, COUNTY shall provide CONTRACTOR with a preliminary monitoring report for review before it is finalized. This report shall contain a summary of information collected or reviewed; the evaluator's assessment, conclusions, and recommendations; and, any requirements or sanctions to be imposed on the CONTRACTOR, such as disallowances, recoupments, or requests for plans of action.

CONTRACTOR will have two (2) weeks to give notice of any disagreement with any of the findings and to present information supporting the provider's position. If appropriate, COUNTY may conduct additional monitoring activities to evaluate the CONTRACTOR's position.

COUNTY shall then finalize and issue its report. If the final report identifies material variations between CONTRACTOR's service activities and the standards required under this agreement, COUNTY may require CONTRACTOR to prepare a written plan of action to address those variations. COUNTY will also have such other remedies as are provided under this agreement.

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 contract and (b) conduct the quality management activities called for by the contract.

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 the 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 duty to provide training and supervision to its staff or 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.

CONTRACTOR shall require all new employees in positions designated as a "covered individuals" to complete four-hour compliance training within the first 30 days of their first day of work. CONTRACTOR shall require all covered individuals to attend at minimum, a four-hour compliance training annually. These trainings shall be conducted by COUNTY or, at COUNTY's discretion, by CONTRACTOR staff, or both, and may address any standards contained in this agreement. Covered individuals who are subject to this training are any CONTRACTOR staff who has or will have responsibility for, or who supervises any person who has responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.

Behavioral Health Bridge Housing (BHBH) Rental Assistance (December 1, 2024 through June 30, 2027)

CONTRACTOR shall provide Rental Assistance to qualified residents in the form of transitional housing environments as part of the Behavioral Health Bridge Housing (BHBH) grant subcontracted through Advancement of Human Potential (AHP). BHBH funding will not supplant other sources of funding, federal or state, that can be used for the purpose of rental assistance for the program target population. This funding will be available from December 1, 2024 through June 30, 2027.

Target Population/Client Eligibility Criteria for BHBH Rental Assistance Funding

1. Individual meets criteria for Medi-Cal Specialty Mental Health Services (SMHS) as outlined in BHIN 21-073.

OR

2. The individual is a CARE Program participant, regardless of whether they meet the criteria in (1).

AND

3. The individual has a homelessness status based on the definition of homelessness used in the ECM policy guide updated July 2023.

BHBH Housing Unit Standards

BHBH housing program units shall meet the Continuum of Care (CoC) Housing Quality Standards (HQS), which is the highest standard, for any stays 90 days or longer.

- **Inspections:** Qualified personnel must inspect all units before spending BHBH funds, and annually throughout the grant period.
- **Deficiencies:** The unit owner has 30 days to correct any deficiencies.
- **State and local codes:** All units must meet state and local codes.

BHBH Program Requirements

CONTRACTOR shall be responsible for cooperation and collaboration with COUNTY staff, including staff providing Housing Navigation services to create the optimal outcomes for participants.

CONTRACTOR shall make referrals to COUNTY Behavioral Health on behalf of participants when they require behavioral health services beyond those provided through the SLP.

CONTRACTOR shall maintain nonmedical client records in the Homeless Management Information System (HMIS). CONTRACTOR shall make policies and procedures specific to SLP program BHBH recipient participants that abide by the following requirements. All BHBH policies and procedures must be approved by COUNTY designated staff.

A. Policies shall include assurances that BHBH funds will not be used to supplant other funding sources available for the same purpose.
B. Policies shall clearly state that homelessness is an eligibility requirement, based on the definition used in the Enhanced Care Management Policy Guide from 2023.
C. Policies shall indicate that Behavioral Health eligibility requirements in use are consistent with BHBH requirements.

Specific Performance Objectives During the Term of this Agreement

1. Housing
    a. 75% of participants will exit the BHBH program to Permanent Housing.

EXHIBIT B-4
COMPENSATION
December 1, 2024, through June 30, 2025
(and each subsequent automatic renewal)

I. Compensation

1. Contract maximum not to exceed $214,742.00 for FY24-25, 25-26 and 26-27. As of July 1, 2027, the contract maximum will revert back to $160,742.
2. Approved Specialty Mental Health Services performed, at any program site, shall be entered into COUNTY EHR. Services entered will be extracted from the EHR by COUNTY HHSA billing team and sent to CONTRACTOR as a report for review and approval.
3. Approved distribution of Behavioral Health Bridge Housing (BHBH) rental assistance funds. Funds will be made available for SLP clients meeting BHBH criteria for rental assistance. Funds are available annually through June 30, 2027.

II. Payment Rates

COUNTY shall compensate CONTRACTOR for contract services provided and properly documented at current Napa County HHSA Medi-Cal rates, as defined in Exhibit E to the Agreement and posted on the Napa County HHSA website. Exhibit E shall control in the event of a conflict between Exhibit E and the information posted on the Napa County HHSA website.

1. A billing unit is defined as one minute of service. Only authorized service activities provided by eligible staff, while providing Medi-Cal eligible services to Napa County Medi-Cal eligible clients, shall qualify for payment. The following requirements apply for claiming of services:

I. Accurate and precise number of minutes shall be reported and billed properly, by a qualified staff member.
II. A maximum of 60 units of time may be reported or claimed for any single client during a one-hour period.
III. Units of time reported or claimed shall not exceed hours worked by eligible staff.
IV. When a single staff member provides eligible service to, or on behalf of, more than one beneficiary at the same time, the staff member's time must be prorated to each beneficiary.
V. When more than one staff member provides an eligible 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.
VI. 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 include clear indication of the clinical necessity for the chosen treatment approach.

VII. 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 and the combined number of clients served.

2. 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.

III. Clients with Medi-CAL and Other Health Coverage (OHC)

Per Federal Regulation, providers must bill all Other Health Coverage (OHC) options prior to submitting claims to COUNTY for Medi-Cal reimbursement. The CONTRACTOR may bill the COUNTY for claims requiring OHC billing and the COUNTY will pre-pay the pending OHC claim. The CONTRACTOR must provide the Explanation of Benefits (EOB) or denial letter along with a copy of the original claim submitted to private insurance within 5 months from the date of service. If the EOB or denial letter is not received by the COUNTY within 5 months from the date of service, the COUNTY will offset the payment for the current period by this pre-paid amount.
OUNTY within 5 months from the date of service, the COUNTY will offset the payment for the current period by this pre-paid amount.

The 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.

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 within 90-days from the date of claim submission, CONTRACTOR may presume denial from the OHC and submit a letter stating that no response was received from the OHC, along with a copy of the original claim submitted to the OHC.

The 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 the COUNTY if OHC eligibility is discovered.

The 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, the COUNTY will assist CONTRACTOR in finding contact information for OHC insurers, but the COUNTY is under no obligation to do so, and this does not alleviate CONTRACTOR from the sole responsibility to do so.

IV. BHBH Rental Assistance Funds (December 1, 2024 through June 30, 2027)

A limited number of clients served under this contract may also qualify for Behavioral Health Bridge Housing (BHBH) rental assistance. Details regarding distinct eligibility and program requirements for BHBH funding are provided in Exhibit A of this agreement.

BHBH maximum rates are **$750/month** per room and shall be invoiced monthly on COUNTY approved invoice form. Total annual BHBH rental assistance shall not exceed $54,000. In the event that the Client does not contribute to the rental payments, COUNTY agrees to pay a fee of $750 per room. If the Client contributes to the rental payments, the amount payable by COUNTY shall be reduced by the amount of the Client's contribution.

V. Required Submissions

A. Budget. Fifteen days prior to the beginning of the Fiscal Year, CONTRACTOR shall submit an estimated Budget consistent with the Fiscal Year contract maximum. CONTRACTOR shall include estimated FTEs, by standardized classification, and identify those providing Direct Client Care. The COUNTY shall supply a revised Budget Template which correlates to standardized classification fields.

B. Invoices. CONTRACTOR shall submit valid and accurate ***Monthly*** itemized invoices to BHInvoices@countyofnapa.org by the ***15th of each month*** for all authorized contract services provided in the preceding ***month***. CONTRACTOR shall use COUNTY HHSA billing team service report to review and approve. Upon CONTRACTOR service approval, CONTRACTOR shall submit approved services as an invoice on agency letterhead with total amount due and service month and year to BHInvoices@countyofnapa.org. BHBH invoices shall be submitted separately by the 15th of the month to BHinvoices@countyofnapa.org.

Validity and accuracy of invoice submission is critical to ensure timely payment of invoices for contracted services. Invoices will be paid within 60 days of receipt of invoices. If COUNTY staff requires any invoice follow-up, clarification, adjustment, or resubmission from CONTRACTOR, the 60-day timeframe for invoice payment resets to the date all outstanding issues are resolved, and the most recently received invoice is confirmed to be valid and accurate.

A. Annual Cost Report. COUNTY may require CONTRACTOR to submit an annual cost report, at no additional cost to COUNTY. If a cost report is required, CONTRACTOR

will be notified, and the cost report will be 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.

VI. Other 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 include, but are not limited to:

1. 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.
2. 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 exception shall be repaid to COUNTY by CONTRACTOR.
3. CONTRACTOR shall reimburse COUNTY for disallowances for payment or lost revenues as identified and discovered by the COUNTY that are attributable to CONTRACTOR's failure to perform in accordance with 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.
4. To the extent CONTRACTOR is required to reimburse the COUNTY under this Paragraph, COUNTY may elect to withhold any payments for past services, offset against any payments for future services which CONTRACTOR provides, or demand reimbursement without offset.
5. 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.

CONTRACTOR's failure to comply with this Agreement may lead at any time to withholding of payments and/or a termination of the Agreement based on breach of contract.