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COUNTY OF SISKIYOU
CONTRACT FOR SERVICES
FOR BOARD OF SUPERVISORS SIGNATURE

This Contract is entered into on the date when it has been both approved by the Board and signed by all other parties to it.

COUNTY: Siskiyou County Health and Human Services Agency
Behavioral Health Division
Sarah Collard, Agency Director
2060 Campus Drive
Yreka, CA 96097
(530) 841-4100 Phone
(530) 841-4133 Fax

And

CONTRACTOR: Remi Vista, Inc.
Stephanie Holmes, Chief Executive Officer
PO Box 494100
Redding, CA 96001
(530) 245-5805 Phone
(530) 245-0340 Fax

ARTICLE 1. TERM OF CONTRACT

1.01 Contract Term: This Contract shall become effective on July 1, 2021 and shall terminate on June 30, 2024, unless terminated in accordance with the provisions of Article 7 of this Contract or as otherwise provided herein.

ARTICLE 2. INDEPENDENT CONTRACTOR STATUS

2.01 Independent Contractor: It is the express intention of the parties that Contractor is an independent contractor and not an employee, agent, joint venture or partner of County. Nothing in this Contract shall be interpreted or construed as creating or establishing the relationship of employer and employee between County and Contractor or any employee or agent of Contractor. Both parties acknowledge that Contractor is not an employee for state or federal tax purposes. Contractor shall retain the right to perform services for others during the term of this Contract.

ARTICLE 3. SERVICES

3.01 Specific Services: Contractor agrees to furnish the following services: Contractor shall provide the services described in Exhibit “A”.No additional services shall be performed by Contractor unless approved in advance in writing by the County stating the dollar value of the services, the method of payment, and any adjustment in contract time or other contract terms. All such services are to be coordinated with County and the results of the work shall be monitored by the Health and Human Services Agency Director or his or her designee.

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3.02 Method of Performing Services: Contractor will determine the method, details, and means of performing the above-described services including measures to protect the safety of the traveling public and Contractor's employees. County shall not have the right to, and shall not, control the manner or determine the method of accomplishing Contractor's services.

3.03 Employment of Assistants: Contractor may, at the Contractor's own expense, employ such assistants as Contractor deems necessary to perform the services required of Contractor by this Contract. County may not control, direct, or supervise Contractor's assistants or employees in the performance of those services.

ARTICLE 4. COMPENSATION

4.01 Compensation: In consideration for the services to be performed by Contractor, County agrees to pay Contractor in proportion to services satisfactorily performed as specified in Exhibit "A", a total not to exceed amount of Two Hundred Twenty Five Thousand and No/100 Dollars ($225,000.00) for each of the three years with the total not to exceed amount of Six Hundred Seventy Five Thousand and No/100 Dollars ($675,000.00) for the term of the contract.

4.02 Invoices: Contractor shall submit detailed invoices for all services being rendered.

4.03 Date for Payment of Compensation: County shall pay within 30 days of receipt of invoices from the Contractor to the County, and approval and acceptance of the work by the County.

4.04 Expenses: Contractor shall be responsible for all costs and expenses incident to the performance of services for County, including but not limited to, all costs of materials, equipment, all fees, fines, licenses, bonds or taxes required of or imposed against Contractor and all other of Contractor's costs of doing business. County shall not be responsible for any expense incurred by Contractor in performing services for County.

ARTICLE 5. OBLIGATIONS OF CONTRACTOR

5.01 Contractor Qualifications: Contractor warrants that Contractor has the necessary licenses, experience and technical skills to provide services under this Contract.

5.02 Contract Management: Contractor shall report to the Health and Human Services Agency Director or his or her designee who will review the activities and performance of the Contractor and administer this Contract.

5.03 Tools and Instrumentalities: Contractor will supply all tools and instrumentalities required to perform the services under this Contract. Contractor is not required to purchase or rent any tools, equipment or services from County.

5.04 Workers' Compensation: Contractor shall maintain a workers' compensation plan covering all its employees as required by California Labor Code Section 3700, either through workers' compensation insurance issued by an insurance company or through a plan of self-insurance certified by the State Director of Industrial Relations. If Contractor elects to be self-insured, the certificate of insurance otherwise required by this Contract shall be replaced with a consent to

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self-insure issued by the State Director of Industrial Relations. Proof of such insurance shall be provided before any work is commenced under this contract. No payment shall be made unless such proof of insurance is provided.

5.05 Indemnification: Contractor shall indemnify and hold County harmless against any and all liability imposed or claimed, including attorney's fees and other legal expenses, arising directly or indirectly from any act or failure of Contractor or Contractor's assistants, employees or agents, including all claims relating to the injury or death of any person or damage to any property. Contractor agrees to maintain a policy of liability insurance in the minimum amount of ($1,000,000) One Million Dollars, to cover such claims or in an amount determined appropriate by the County Risk Manager. If the amount of insurance is reduced by the County Risk Manager such reduction must be in writing. Contractor shall furnish a certificate of insurance evidencing such insurance and naming the County as an additional insured for the above-cited liability coverage prior to commencing work. It is understood that the duty of Contractor to indemnify and hold harmless includes the duty to defend as set forth in Section 2778 of the California Civil Code. Acceptance by County of insurance certificates and endorsements required under this Contract does not relieve Contractor from liability or limit Contractor's liability under this indemnification and hold harmless clause. This indemnification and hold harmless clause shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply. By execution of this Contract, Contractor acknowledges and agrees to the provisions of this Section and that it is a material element of consideration.

5.06 General Liability and Automobile Insurance: During the term of this Contract, Contractor shall obtain and keep in full force and effect a commercial, general liability and automobile policy or policies of at least ($1,000,000) One Million Dollars, combined limit for bodily injury and property damage; the County, its officers, employees, volunteers and agents are to be named additional insured under the policies, and the policies shall stipulate that this insurance will operate as primary insurance for work performed by Contractor and its sub-contractors, and that no other insurance effected by County or other named insured will be called on to cover a loss covered thereunder. All insurance required herein shall be provided by a company authorized to do business in the State of California and possess at least a Best A:VII rating or as may otherwise be acceptable to County. The General Liability insurance shall be provided by an ISO Commercial General Liability policy, with edition dates of 1985, 1988, or 1990 or other form satisfactory to County. The County will be named as an additional insured using ISO form CG 2010 1185 or the same form with an edition date no later than 1990, or in other form satisfactory to County.

5.07 Certificate of Insurance and Endorsements: Contractor shall obtain and file with the County prior to engaging in any operation or activity set forth in this Contract, certificates of insurance evidencing additional insured coverage as set forth in paragraphs 5.04 and 5.10 and which shall provide that no cancellation, reduction in coverage or expiration by the insurance company will be made during the term of this Contract, without thirty (30) days written notice to County prior to the effective date of such cancellation. **Naming the County as a "Certificate Holder" or other similar language is NOT sufficient satisfaction of the requirement.** Prior to commencement of performance of services by Contractor and prior to any obligations of County, contractor shall file certificates of insurance with County showing that Contractor has in effect the insurance required by this Contract. Contractor shall file a new or amended certificate on the certificate then on file. **If changes are made during the term of this Contract, no work shall be performed under this agreement, and no payment may be made until such certificate of**

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insurance evidencing the coverage in paragraphs, 5.05, the general liability policy set forth in 5.06 and 5.10 are provided to County.

5.08 Public Employees Retirement System (CalPERS): In the event that Contractor or any employee, agent, or subcontractor of Contractor providing services under this Contract is determined by a court of competent jurisdiction or the Public Employees Retirement System (CalPERS) to be eligible for enrollment in CalPERS as an employee of the County, Contractor shall indemnify, defend, and hold harmless County for the payment of any employee and/or employer contributions of CalPERS benefits on behalf of Contractor or its employees, agents, or subcontractors, as well as for the payment of any penalties and interest on such contributions, which would otherwise be the responsibility of County. Contractor understands and agrees that his personnel are not, and will not be, eligible for memberships in, or any benefits from, any County group plan for hospital, surgical or medical insurance, or for membership in any County retirement program, or for paid vacation, paid sick leave, or other leave, with or without pay, or for any other benefit which accrues to a County employee.

5.09 IRS/FTB Indemnity Assignment: Contractor shall defend, indemnify, and hold harmless the County, its officers, agents, and employees, from and against any adverse determination made by the Internal Revenue Service of the State Franchise Tax Board with respect to Contractor's "independent contractor" status that would establish a liability for failure to make social security and income tax withholding payments.

5.10 Professional Liability: If Contractor or any of its officers, agents, employees, volunteers, contactors or subcontractors are required to be professionally licensed or certified by any agency of the State of California in order to perform any of the work or services identified herein, Contractor shall procure and maintain in force throughout the duration of the Contract a professional liability insurance policy with a minimum coverage level of ($1,000,000) One Million Dollars, or as determined in writing by County's Risk Management Department.

5.11 State and Federal Taxes: As Contractor is not County's employee, Contractor is responsible for paying all required state and federal taxes. In particular:

a. County will not withhold FICA (Social Security) from Contractor's payments;

b. County will not make state or federal unemployment insurance contributions on behalf of Contractor.

c. County will not withhold state or federal income tax from payment to Contractor.

d. County will not make disability insurance contributions on behalf of Contractor.

e. County will not obtain workers' compensation insurance on behalf of Contractor.

5.12 Records: All reports and other materials collected or produced by the Contractor or any subcontractor of Contractor shall, after completion and acceptance of the Contract, become the property of County, and shall not be subject to any copyright claimed by the Contractor, subcontractor, or their agents or employees. Contractor may retain copies of all such materials exclusively for administration purposes. Any use of completed or uncompleted documents for other projects by Contractor, any subcontractor, or any of their agents or employees, without the prior written consent of County is prohibited. It is further understood and agreed that all plans, studies, specifications, data magnetically or otherwise recorded on computer or computer diskettes, records, files, reports, etc., in possession of the Contractor relating to the matters covered by this Contract shall be the property of the County, and Contractor hereby agrees to deliver the same to the County upon request. It is also understood and agreed that the

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documents and other materials including but not limited to those set forth hereinabove, prepared pursuant to this Contract are prepared specifically for the County and are not necessarily suitable for any future or other use.

5.13 Contractor's Books and Records: Contractor shall maintain any and all ledgers, books of account, invoices, vouchers, canceled checks, and other records or documents evidencing or relating to charges for services or expenditures and disbursements charged to the County for a minimum of five (5) years, or for any longer period required by law, from the date of final payment to the Contractor under this Contract. Any records or documents required to be maintained shall be made available for inspection, audit and/or copying at any time during regular business hours, upon oral or written request of the County.

5.14 Assignability of Contract: It is understood and agreed that this Contract contemplates personal performance by the Contractor and is based upon a determination of its unique personal competence and experience and upon its specialized personal knowledge. Assignments of any or all rights, duties or obligations of the Contractor under this Contract will be permitted only with the express written consent of the County.

5.15 Warranty of Contractor: Contractor warrants that it, and each of its personnel, where necessary, are properly certified and licensed under the laws and regulations of the State of California to provide the special services agreed to.

5.16 Withholding for Non-Resident Contractor: Pursuant to California Revenue and Taxation Code Section 18662, payments made to nonresident independent contractors, including corporations and partnerships that do not have a permanent place of business in this state, are subject to 7 percent state income tax withholding.

Withholding is required if the total yearly payments made under this contract exceed $1,500.00.

Unless the Franchise Tax Board has authorized a reduced rate or waiver of withholding and County is provided evidence of such reduction/waiver, all nonresident contractors will be subject to the withholding. It is the responsibility of the Contractor to submit the Waiver Request (Form 588) to the Franchise Tax Board as soon as possible in order to allow time for the Franchise Tax Board to review the request.

5.17 Compliance with Child, Family and Spousal Support Reporting Obligations: Contractor's failure to comply with state and federal child, family and spousal support reporting requirements regarding contractor's employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment relating to child, family and spousal support obligations shall constitute a default under this Contract. Contractor's failure to cure such default within ninety (90) days of notice by County shall be grounds for termination of this Contract.

5.18 Conflict of Interest: Contractor covenants that it presently has no interest and shall not acquire an interest, direct or indirect, financial or otherwise, which would conflict in any manner or degree with the performance of the services hereunder. Contractor further covenants that, in the performance of this Contract, no subcontractor or person having such an interest shall be used or employed. Contractor certifies that no one who has or will have any financial interest under this contract is an officer or employee of County.

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5.19 Compliance with Applicable Laws: Contractor shall comply with all applicable federal, state and local laws now or hereafter in force, and with any applicable regulations, in performing the work and providing the services specified in this Contract. This obligation includes, without limitations, the acquisition and maintenance of any permits, licenses, or other entitlements necessary to perform the duties imposed expressly or impliedly under this Contract.

5.20 Bankruptcy: Contractor shall immediately notify County in the event that Contractor ceases conducting business in the normal manner, becomes insolvent, makes a general assignment for the benefit of creditors, suffer or permits the appointment of a receiver for its business or assets, or avails itself of, or becomes subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors.

5.21 Health Insurance Portability and Accountability Act (HIPAA): Contractor agrees to the terms and conditions set forth in the "Business Associates Agreement" attached hereto as Exhibit "C" and those terms and conditions are hereby incorporated into the Contract by reference. Additionally, Contractor shall comply with, and assist SCHHSA in complying with, the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA), as follows.

A. Use or Disclosure of Protected Health Information: Contractor may use or disclose protected health information (PHI) to perform its obligations under the Contract, provided that such use or disclosure does not violate this Agreement, is not prohibited by the Health Insurance Portability and Accountability Act (HIPAA) including, but not limited to, the provisions of Title 42, United States Code, Section 1320d et seq. and Title 45, Code of Federal Regulations (C.F.R.), Parts 142, 160, 162 and 164, or does not exceed the scope of how County could use or disclose the information.

Contractor shall not use, disclose or allow the disclosure of PHI except as permitted herein or as required or authorized by law. Contractor shall implement appropriate safeguards to prevent use or disclosure of PHI other than as provided herein. At the request of and in the time and manner designated by County, Contractor shall provide access to PHI in a designated record set as required by 45 C.F.R. Section 164.524. Contractor shall report to County any use or disclosure of PHI not provided for herein or HIPAA regulations.

If Contractor provides PHI to a third party, including officers, agents, employees, volunteers, contractors and subcontractors, pursuant to the terms of the Contract, Contractor shall ensure that the third party complies with all HIPAA regulations and the terms set forth herein.

B. Documentation and Accounting of Uses and Disclosures: Contractor shall document any disclosures of PHI in a manner that would allow County to respond to a request for an accounting of disclosures of PHI in accordance with 45 C.F.R. Section 164.528. Contractor shall provide County, in a time and manner designated by County, all information necessary to respond to a request for an accounting of disclosures of PHI.

C. Amendments to Designated Record Sets: In accordance with 45 C.F.R. Section 164.526, Contractor agrees to amend PHI in its possession as requested by an individual or as directed by County, in a time and manner designated by County.

D. Access to Records: Contractor shall make available to County or the Secretary of the United States Department of Health and Human Services (HHS), in the time and manner designated

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by County or HHS, any records related to the use, disclosure and privacy protections of PHI for the purpose of investigating or auditing County's compliance with HIPAA regulations.

E. Termination of Agreement: Upon County's knowledge of a material breach of these provisions or HIPAA regulations, County shall, at its option, either provide Contractor with an opportunity to cure the breach or immediately terminate this Contract. If Contractor is given an opportunity to cure the breach but fails to do so within the time specified by County, County may terminate the Contract without further notice.

F. Destruction of PHI: Upon termination of this Contract, Contractor shall return to County all PHI required to be retained and return or destroy all other PHI to comply with HIPAA regulations. This provision shall apply to PHI in the possession of Contractor's officers, agents, employees, volunteers, contractors and subcontractors who shall retain no copies of the PHI. If Contractor determines that returning or destroying the PHI is not feasible, Contractor shall provide County with notice specifying the conditions that make return or destruction not feasible. If County agrees that return of the PHI is not feasible, Contractor shall continue to extend the protections of this provision to the PHI for so long as Contractor or its officers, agents, employees, volunteers, contractors or subcontractors maintain such PHI.

5.22 Nondiscrimination: Contractor agrees to the terms and conditions set forth in the "Nondiscrimination in State and Federally-Assisted Programs" addendum, attached hereto as Exhibit "B" and those terms and conditions are hereby incorporated into the Contract by reference.

5.23 Grievance Procedure: If Contractor is required by ordinance, regulation, policy, the California Department of Social Services, County or other authority to have a procedure for filing and considering grievances, Contractor shall provide County with a copy of Contractor's grievance procedure prior to providing services under this Contract.

5.24 Child Abuse and Neglect Reporting: Contractor shall comply with all state and federal laws pertaining to the reporting of child abuse and/or neglect. Contractor's officers, employees, agents and volunteers shall report all known or suspected instances of child abuse and/or neglect to the Child Protective Services agency or other agency as required by Penal Code Section 11164 et seq.

5.25 Confidentiality: All information and records obtained in the course of providing services under this Agreement shall be confidential pursuant to Section 5328 of the Welfare and Institutions Code in accordance with applicable State and Federal law.

5.26 Patients' Rights: Contractor shall give the patients notice of their rights pursuant to and in compliance with: California Welfare and Institutions Code Section 5323; California Administrative Code, Title 9, Chapter 1, Subchapter 4, Article 6. In addition, in all facilities providing the services described herein, the Contractor shall have prominently posted in the predominant languages of the community a list of the patient's rights.

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ARTICLE 6. OBLIGATIONS OF COUNTY

6.01 Cooperation of County: County agrees to comply with all reasonable requests of Contractor (to provide reasonable access to documents and information as permitted by law) necessary to the performance of Contractor's duties under this Contract.

ARTICLE 7. TERMINATION

7.01 Termination on Occurrence of State Events: This Contract shall terminate automatically on the occurrence of any of the following events:

1. Bankruptcy or insolvency of Contractor
2. Death of Contractor

7.02 Termination by County for Default of Contractor: Should Contractor default in the performance of this Contract or materially breach any of its provisions, County, at County's option, may terminate this Contract by giving written notification to Contractor.

7.03 Termination for Convenience of County: County may terminate this Contract at any time by providing a notice in writing to Contractor that the Contract is terminated. Said Contract shall then be deemed terminated and no further work shall be performed by Contractor. If the Contract is so terminated, the Contractor shall be paid for that percentage of the phase of work actually completed, based on a pro rata portion of the compensation for said phase satisfactorily completed at the time of notice of termination is received.

7.04 Termination of Funding: County may terminate this Contract in any fiscal year in that it is determined there is not sufficient funding. California Constitution Article XVI Section 18.

ARTICLE 8. GENERAL PROVISIONS

8.01 Notices: Any notices to be given hereunder by either party to the other may be effected either by personal delivery in writing or by mail, registered or certified, postage prepaid or return receipt requested. Mailed notices shall be addressed to the parties at the addresses appearing in the introductory paragraph of this Contract, but each party may change the address by written notice in accordance with the paragraph. Notices delivered personally will be deemed communicated as of actual receipt; mailed notices will be deemed communicated as of two (2) days after mailing.

County
Siskiyou County Health and Human Services Agency
Attn: Rose Bullock, Administrative Services Manager II
2060 Campus Drive
Yreka, California 96097
(530) 841-4732 Phone
rbullock@co.siskiyou.ca.us

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Contractor Remi Vista, Inc.
Attn: Stephanie Holmes, Chief Executive Officer
PO Box 494100
Redding, CA 96001
(530) 245-5805 Phone
(530) 245-0340 Fax

8.02 Entire Agreement of the Parties: This contract supersedes any and all contracts, either oral or written, between the Parties hereto with respect to the rendering of services by Contractor for County and contains all the covenants and contracts between the parties with respect to the enduring of such services in any manner whatsoever. Each Party to this Contract acknowledges that no representations, inducements, promises, or contract, orally or otherwise, have been made by any party, or anyone acting on behalf of any Party, which are not embodied herein, and that no other contract, statement, or promise not contained in this Contract shall be valid or binding. Any modification of this Contract will be effective only if it is in writing signed by the Party to be charged and approved by the County as provided herein or as otherwise required by law.

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

8.04 Attorney's Fees: If any action at law or in equity, including an action for declaratory relief, is brought to enforce or interpret the provisions of this Contract, the prevailing Party will be entitled to reasonable attorney's fees, which may be set by the court in the same action or in a separate action brought for that purpose, in addition to any other relief to which that party may be entitled.

8.05 Conformance to Applicable Laws: Contractor shall comply with the standard of care regarding all applicable federal, state and county laws, rules and ordinances. Contractor shall not discriminate in the employment of persons who work under this contract because of race, the color, national origin, ancestry, disability, sex or religion of such person.

8.06 Waiver: In the event that either County or Contractor shall at any time or times waive any breach of this Contract by the other, such waiver shall not constitute a waiver of any other or succeeding breach of this Contract, whether of the same or any other covenant, condition or obligation.

8.07 Governing Law: This Contract and all matters relating to it shall be governed by the laws of the State of California and the County of Siskiyou and any action brought relating to this Contract shall be brought exclusively in a state court in the County of Siskiyou.

8.08 Reduction of Consideration: Contractor agrees that County shall have the right to deduct from any payments contracted for under this Contract any amount owed to County by Contractor as a result of any obligation arising prior or subsequent to the execution of this contract. For purposes of this paragraph, obligations arising prior to the execution of this contract may include, but are not limited to any property tax, secured or unsecured, which tax is in arrears. If County exercises the right to reduce the consideration specified in this Contract, County shall give Contractor notice of the amount of any off-set and the reason for the deduction.

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8.09 Negotiated Contract: This Contract has been arrived at through negotiation between the parties. Neither party is to be deemed the party which prepared this Contract within the meaning of California Civil Code Section 1654. Each party hereby represents and warrants that in executing this Contract it does so with full knowledge of the rights and duties it may have with respect to the other. Each party also represents and warrants that it has received independent legal advice from its attorney with respect to the matters set forth in this Contract and the rights and duties arising out of this Contract, or that such party willingly foregoes any such consultation.

8.10 Time is of the Essence: Time is of the essence in the performance of this Contract.

8.11 Materiality: The parties consider each and every term, covenant, and provision of this Contract to be material and reasonable.

8.12 Authority and Capacity: Contractor and Contractor's signatory each warrant and represent that each has full authority and capacity to enter into this Contract.

8.13 Binding on Successors: All of the conditions, covenants and terms herein contained shall apply to, and bind, the heirs, successors, executors, administrators and assigns of Contractor. Contractor and all of Contractor's heirs, successors, executors, administrators, and assigns shall be jointly and severally liable under the Contract.

8.14 Cumulation of Remedies: All of the various rights, options, elections, powers and remedies of the parties shall be construed as cumulative, and no one of them exclusive of any other or of any other legal or equitable remedy which a party might otherwise have in the event of a breach or default of any condition, covenant or term by the other party. The exercise of any single right, option, election, power or remedy shall not, in any way, impair any other right, option, election, power or remedy until all duties and obligations imposed shall have been fully performed.

8.15 No Reliance On Representations: Each party hereby represents and warrants that it is not relying, and has not relied upon any representation or statement made by the other party with respect to the facts involved or its rights or duties. Each party understands and agrees that the facts relevant, or believed to be relevant to this Contract, may hereunder turn out to be other than, or different from the facts now known to such party as true, or believed by such party to be true. The parties expressly assume the risk of the facts turning out to be different and agree that this Contract shall be effective in all respects and shall not be subject to rescission by reason of any such difference in facts.

SIGNATURES TO FOLLOW

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IN WITNESS WHEREOF, County and Contractor have executed this agreement on the dates set forth below, each signatory represents that he/she has the authority to execute this agreement and to bind the Party on whose behalf his/her execution is made.

COUNTY OF SISKIYOU:

Date: _____

_____
Brandon A. Criss, Chair Board of Supervisors
County of Siskiyou
State of California

ATTEST:
LAURA BYNUM
Clerk, Board of Supervisors

By: _____
Deputy

CONTRACTOR: Remi Vista, Inc.

Date: 1/10/2022

DocuSigned by:
Stephanie Holmes
7620775DA9FF44C...

_____
Stephanie Holmes, Chief Executive Officer

Date: 1/10/2022

DocuSigned by:
Troy Foster
F0CA7D3F5B97411...

_____
Troy Foster, Quality Assurance Officer

License No.: 28502
(Licensed in accordance with an act providing for the registration of contractors)

Note to Contractor: For corporations, the contract must be signed by two officers. The first signature must be that of the chairman of the board, president or vice-president; the second signature must be that of the secretary, assistant secretary, chief financial officer or assistant treasurer. (Civ. Code, Sec. 1189 & 1190 and Corps. Code, Sec. 313.)

TAXPAYER I.D. On File

ACCOUNTING:

Fund	Organization	Account	Activity Code
2122	401030	723016	

Encumbrance number

Amount not to exceed:
$225,000.00 FY21/22
$225,000.00 FY22/23
$225,000.00 FY23/24
$675,000.00 Total

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I. Scope of Services

Services will be provided in the home or community to Siskiyou County youth and their families who have been assessed and referred by County as in need of Specialty Mental Health Services and authorized by County.

A. Contractor, for County’s benefit shall perform medically necessary and clinically appropriate professional specialty mental health services as set out in this Exhibit “A”, attached hereto and by this reference fully incorporated herein, subject to the following conditions:

1) Authorization of client by County: Contractor will provide services to the client(s) that have been assessed and authorized by County to receive services from Contractor, subject to Contractor’s acceptance of such client(s) for services. Such client(s) authorized by County and accepted by Contractor shall be referred to as “Authorized Clients”.

2) Authorization of services provided: Contractor will provide to authorized client(s) only the Specialty Mental Health Service(s) authorized in advance (“Authorized Services”) by County for provision to that/those specific client(s).

3) Disclaimer: Nothing in (1) or (2) above shall be construed to prevent Contractor from providing services not authorized for payment by County to authorized client(s), nor from providing services to unauthorized client(s), if the clinical judgment of Contractor so indicates. However, such services to such client(s) shall be construed to be outside the scope of this Agreement for purposes of reimbursement to Contractor and any other benefits or protections provided to Contractor by it. No obligation on the part of County to reimburse, indemnify or defend Contractor is expressed nor implied by provision of services outside the scope of this Agreement.

4) Nondiscrimination: Contractor will not serve County client(s), as such, any differently from the way other client(s) are served. Contractor will not discriminate against County client(s) in the provision of services with respect to the quality or scheduling of services, treatment modalities, facilities, amenities, or manner of client interaction with Contractor and Contractor’s staff. Identity of County client(s) as such will not be disclosed by Contractor or Contractor’s staff to Contractor’s other client(s), professional peers or any other party except as required by law.

5) Standard of Care: In providing services to County client(s), Contractor will adhere to the Medi-Cal certification guidelines for Specialty Mental Health Services as specified in the County Organizational Provider Manual for Specialty Mental Health Services, Exhibit “B”, incorporated herein by reference. All services will be provided in a culturally competent manner with respect for cultural values, traditions and differences. These standards will apply without limitation by exception, with respect to the quality of services provided, observance of client(s)’ rights, client confidentiality and records maintenance.

6) Payment in Full: The payment rates specified in the Fee Schedule Section II, D.1) Compensation and Billing, in this Exhibit “A” of this Agreement, attached hereto and by this reference fully incorporated herein will be accepted by Contractor as payment in full, for Authorized Services provided to Authorized Clients.

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7) Number of Referrals: Contractor understands that County cannot guarantee a specified level of referrals. However, County agrees to use its best efforts in referring appropriate clients to Contractor.

8) Timely Access to Services: In accordance with 42 C.F.R.§ 438.206 (c) (1) and Title 9 California Code of Regulations 1810.405, Contractor shall ensure timely access to care and services, taking into account the urgency of need for services. Contractor hours of operation and appointment times for Medi-Cal beneficiaries shall be no less than the hours of operation offered to non-Medi-Cal or commercial beneficiaries or comparable to Medicaid fee-for-service, if the provider serves only Medicaid beneficiaries.

B. Specialty Mental Health services may include:

1) Services provided "In County":

- Mental Health Services
- Katie A Services/ ICC/ IHBS
- Crisis Intervention
- Rehabilitation
- Therapeutic Behavioral Service
- Intensive Home-Based Service
- Mental Health Services Act/Full Service Partnership

2) Services provided "Out of County":

- Mental Health Services
- Katie A Services/ ICC/ IHBS
- Rehabilitation
- Therapeutic Behavioral Services
- Psychological Evaluations
- Intensive Home-Based Service

3) Mental Health Services

a) Definition: "Mental Health Services" means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Services may include but are not limited to assessment, plan development, individual or group therapy, rehabilitation and collateral. *Title IX, Division 1, §1810.227.*

b) "ICC/IHBS" means Intensive Care Coordination, which is facilitate implementation of the cross-system/ multi agency collaborative services approach. Intensive Home Based Services are targeted to the Katie A subclass (and their significant support persons) and is expected to be of significant intensity to address the intensive mental health needs of the child/youth and will be predominantly delivered outside an office setting and in the home, school, or community. *Medi-Cal Manual for Intensive CareCoordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members.*

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4) Crisis Intervention Services

a) Definition: “Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site and staffing requirements as described in Sections 1840.338 and 1840.348 of the California Code of Regulations, Title 9. Crisis Intervention is defined in Title IX, Division 1, § 1810.209.

b) Contact and Site Requirements: Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or a significant support person and may be provided anywhere in the community. Title 9, Section 1840.336.

5) Therapeutic Behavioral Services

a) Definition: Therapeutic Behavioral Services are defined as one-to-one therapeutic contact between a mental health provider and a beneficiary for short-term periods which are designed to maintain the child/youth’s residential placement (group home, foster care facility, etc.) at the lowest appropriate level of care by resolving target behaviors and achieving short-term goals. Therapeutic Behavioral Services may be provided in the community, client’s parent’s home, or at the beneficiary’s residential placement.

b) Authorization: Therapeutic Behavioral Services will be preauthorized on a case-by-case basis, for a set number of hours per week as established in the Therapeutic Behavioral Services Plan for the client, developed by the treatment team and authorized by the appropriate County Program Coordinator. Therapeutic Behavioral Services Plans will be reviewed and revised on at least a monthly basis. Services will be re-authorized based on the amended plan. Therapeutic Behavioral Services shall not be provided in one lump sum of hours per session. Sessions should focus on specific skills associated with client’s functional impairment.

c) Claims Payment: Therapeutic Behavioral Services claims shall be paid for direct service provision, travel time to and from the assignment, and documentation time. Claims must be submitted on the CMS (HCFA) 1500 Claim Form, with appropriate documentation as outlined in Exhibit “B” or other format acceptable to County.

d) Timeliness: The Contractor agrees to arrange Therapeutic Behavioral Services within three (3) working days of receipt of the referral for standard TBS services, referrals for urgent Therapeutic Behavioral Services will be provided as soon as possible and begin prior to three (3) working days following the receipt of that referral.

e) Documentation: In addition to medical records documentation, Therapeutic Behavioral Services providers shall institute procedures to ensure that all

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occurrences of actual or potential harm and/or allegations of verbal and/or physical insult, injury or harm between and/or among beneficiaries, care-givers, and/or providers are documented on a County Incident Report and forwarded to County within twenty-four (24) hours of the event.

f) Qualification and Supervision of Therapeutic Behavioral Aides: Provider's employees serving in the role of Therapeutic Behavioral Aide shall hold at least an Associate's Degree in a mental-health related field and have four to six years of clinically related work experience.

g) Contractor shall provide and document supervision of Therapeutic Behavioral Aides, by a licensed clinician, in the ratio of one (1) hour for every forty (40) hours worked.

C. Documentation: Contractor will develop and maintain complete clinical records as required by law, plus additional datasets reasonably required by County. Such information includes but is not limited to that required to substantiate a claim against County for reimbursement for services, and to permit County to carry out its Medi-Cal Reimbursement processing and Quality Improvement activities. This information will be reasonably available, in an appropriate format, to County and to any agency which may lawfully require it for purposes of fulfilling or monitoring County's requirements and obligations. Such purposes include, but are not limited to, authorized review for fiscal audits, program compliance, and client complaints. All documentation is to be completed in accordance with the County's Progress Notes & Late Entry Documentation (Clin16-06) as outlined in Exhibit "B", Attachment 7. Documentation is to be completed and signed by provider within 5 days from the date of service. Any documentation outside of this timeline will be denied, see Attachment 7. All documentation completed after the date of service must include the words "Late Entry" at the top of the note. In addition, all notes must have a "Start" time at the top of the narrative. All clients that are shared with our staff psychiatric providers must receive treatment under the diagnosis established by the psychiatric provider. It is the responsibility of the Contractor to contact the psychiatric provider or their nurse to determine the correct working diagnosis. All treatment plans will be coordinated between Contractor and the County and will be updated at a minimum of 1 time per year and all necessary signatures will be obtained within the State's regulations.

D. Collaboration: Contractor will provide view only access of County authorized client charts in the electronic health record (EHR) to County supervisors, access, and quality management for the purposes of case collaboration, utilization management, and quality review. In the event Contractor is not able to provide (EHR) view only access, the Contractor will provide regular bi-weekly progress notes to County members of the treatment team and notify County treatment team members of any significant changes in client status by the end of the following business day.

E. Quality Improvement Activities: It is mutually understood and agreed that Contractor will participate actively in County's Quality Improvement program, including but not limited to provision of case-level or aggregated data on clinical practice and outcomes, testing the efficacy of specific clinical and non-clinical interventions, guarding the confidentiality of data provided by other providers, and participating in Quality Improvement project teams. Clinical data required to be provided by Contractor may include case-level or aggregated information about Contractor's client(s) who are not County client(s), for purposes of identifying patterns of practice and compliance with the nondiscrimination requirements of this Agreement.

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Contractor will have the option of participating in Quality Improvement projects supplemental to those in which the program's participation is required and reimbursed by County. Results of all County Quality Improvement studies will be made available to Contractor without a fee, and will be provided to Contractor within ten (10) business days after conclusion of a study and within ten (10) business days of Contractor's request.

F. Quality Improvement/Utilization Review: Contractor shall be fully reimbursed at the maximum allowable rate for reasonable expenses incurred, including but not limited to, supplying specialty staff trainings beyond those sponsored by the County Quality Management staff and/or performing internal Utilization Review to ensure compliance with all State and Federal guidelines pertaining to the maintenance and security of confidential client records.

G. County Sponsored Trainings: Contractor will have access to attend appropriate County trainings as they relate to the services provided pursuant to this Agreement.

H. Problem Resolution/Appeals Process: It is mutually agreed and understood that except as specifically provided by law, Contractor will employ County's provider problem resolution and appeals process as its sole means to resolve any disputes with County to which the problem resolution and appeals process applies including but not limited to those arising from denial, reduction or termination of services, claims processing or reimbursement for services. Contractor will provide County such information as is reasonably necessary to resolve such disputes. County's problem resolution and appeals process is fully explained in Exhibit "B", Organizational Provider Manual for Specialty Mental Health Services. It is mutually agreed and understood that Contractor will comply with County's process for managing client complaints, including but not limited to posting notices and forms in Contractor's facility and providing such information as may reasonably be required to resolve client complaints.

I. Contractor Qualifications: It is mutually agreed and understood that Contractor represents and warrants that Specialty Mental Health Services provided meet the certification standards of a caliber and level as those established in the Short-Doyle Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management. Contractor further represents and warrants that the program will meet those requirements for the duration of the term of this Agreement and that if for any reason the program should fail to meet any requirement during the term of this Agreement, the Contractor will so notify County within one working day by telephone and document facsimile transmittal. Upon receipt of such notice County may at its option take such action, as it deems necessary to protect the welfare of its client(s), including but not limited to removal of its beneficiaries from Contractor's care.

J. Accreditation: If County seeks accreditation or other external certification, its application will be on the basis of the entire plan as the applying entity, including all contracted providers for purposes of their relationship with County.

K. Contractor shall maintain all patient records in compliance with all appropriate Federal, State and Local requirements. Contractor will not maintain physical custody of any original patient records. Original documentation shall be filed with County.

L. Contractor shall abide by the requirements of Federal and State statutes and regulations with regard to patients' rights, and that nothing in this Agreement will be construed to replace or conflict with the authority and responsibility of the patient's Rights Advocates as specified at Welfare and Institutions Code Section 5520.

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M. Reports to Agency: Contractor shall report to the Siskiyou County Health and Human Services Agency on a quarterly basis. Reports shall include, but not be limited to, the number of Authorized Clients served, the amount billed to County for Medi-Cal authorized reimbursement, and any change in staffing which may affect the level of service to be provided pursuant to this agreement.

II. Compensation and Billing

A. County will pay Contractor on the basis of a valid claim for reimbursement as specified in Exhibit "B". For purposes of this section a valid claim means one submitted in the format of HCFA 1500 or a County acceptable format, containing correctly entered information, sufficient to document that an authorized service was provided to an authorized client by Contractor.

B. Determination of the validity of a claim rests with County and will be established by periodic Utilization Review of Contractor activities by County staff. When a claim is determined to be invalid, in whole or in part, County will not pay that portion of the claim and so notify Contractor in writing within ten (10) working days of such determination the reason why the claim was found to be invalid. County shall give Contractor the option of resubmitting the claim for validation and payment once it is complete or corrected. Documentation including progress notes and claims must be resubmitted to the County within 15 days of denial notice.

C. County will reimburse Contractor for provision of Authorized Services to Authorized client(s) subject to the following conditions: Monthly, Contractor shall submit to County's designated representative an invoice for the service performed over the period specified. A County representative shall evaluate the quality of the service performed, and if found to be satisfactory, shall initiate payment process.

1. County payment rates: County will pay Contractor on the basis of the payment rates specified in this Exhibit, less any obligation described in condition (a), (Charges to Beneficiaries) and condition (b) (Coordination of Benefits) below, as payment in full for all services rendered by Contractor pursuant to this Agreement.

    a. Charges to Beneficiaries: Although some County clients are required by State law to contribute to the cost of their care, Contractor will only accept Authorized Clients with Full Scope Medi-Cal Benefits.

    b. Coordination of Benefits: Although some County clients have mental health insurance through another payor, Contractor will only accept Authorized Clients with Full Scope Medi-Cal Benefits.

2. Timely Payment: Claims will be submitted by Contractor to County bi-weekly or a time period mutually agreed upon. Claims not submitted timely may be denied by County. County shall pay Contractor at the address specified herein, within 30 days as specified in Article 4.03, Date for Payment of Compensation. A resubmitted claim will be processed for payment with Contractor's next current claim in the same payment cycle.

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D. Fee Schedule:

1. Specialty Mental Health Services as described in this Exhibit:

Case Management Services	$2.02 per minute
Mental Health Services	$2.60 per minute
Therapeutic Behavioral Services	$2.60 per minute
Crisis Services	$3.58 per minute
Intensive Home –Based Service	$2.60 per minute

2. No reimbursement shall be higher than the rate at which reimbursement will be made to County for services provided by Contractor, both for Specialty Mental Health Services and Case Management.

I. Cost Reports and Settlement

A. Contractor shall submit a separate detailed Mental Health Provider Cost Report ("Cost Report") in the format prescribed by the California Department of Health Care Services (DHCS) and a complete Financial Statement no later than 90 days after the end of the fiscal year. The Cost Report shall calculate the cost per unit as the lower of actual costs or published charges.

B. Contractor may use unaudited financial statements as the basis of cost information for completion of the Cost Report and Financial Statement. Contractor shall submit a copy of the unaudited financial statements with the completed Cost Report and Financial Statement. In addition, Contractor shall submit to County an independent audit report conducted by a Certified Public Accountant in accordance with OMB Circular A133 within 276 days after the close of each County fiscal year during which this agreement is in effect.

C. Upon completion of the County Cost Report, which includes the Contractor's cost report data, County may conduct a settlement review. In the event the Cost Report settlement review identifies an overpayment to Contractor, County will invoice Contractor and Contractor shall reimburse County the full overpayment amount within 60 days.

D. DHCS will review the submitted County Cost Report and issue a Preliminary Cost Report Settlement to County. DHCS will also conduct a Cost Report Audit which results in a Final Cost Report Settlement. In the event that either the DHCS preliminary settlement or final settlement indicates a denial or disallowance of services provided by Contractor or any other irregularity or errors of omission or commission irregularity on the part of Contractor which leads to a financial recoupment, County shall invoice Contractor for the associated amount and Contractor shall reimburse County the full amount within 60 days.

E. Compensation for services rendered subsequent to the Cost Report and Financial Statement due dates may be withheld from Contractor at County's sole discretion until the Cost Report and Financial Statement have been received by County.

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F. All provisions in this section shall survive the termination, expiration, or cancellation of this agreement.

IV. Compliance and Audits

Contractor shall ensure that all services and documentation shall comply with all applicable requirements in the DHCS-MHP Contract No. 17-94617 located at: https://www.co.siskiyou.ca.us/sites/default/files/fileattachments/behavioral_health/page/1381/bhs-20180905_specialty_mental_health_service_agreement.pdf

A. Contractor shall comply with all applicable Medicaid laws, regulations, and contract provisions, including the terms of the 1915(b) Waiver and any Special Terms and Conditions.

B. Contractor shall be subject to audit, evaluation, and inspection of any books, records, contracts, computer or electronic systems that pertain to any aspect of the services and activities performed, in accordance with 42 CFR §§ 438.3(h) and 438.230(c)(3).

C. Contractor shall make available, for the purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medi-Cal beneficiaries.

D. Should the State, CMS, or the HHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Contractor at any time.

E. County will monitor performance of Contractor on an ongoing basis for compliance with the terms of the DHCS-MHP Contract. Contractor's performance shall be subject to periodic formal review by County.

F. Contractor and any of its officers, agents, employees, volunteers, contractors, or subcontractors agree to consent to criminal background checks including fingerprinting when required to do so by DHCS or by the level of screening based on risk of fraud, waste, or abuse as determined for that category of provider.

G. Contractor shall allow inspection, evaluation, and audit of its records, documents, and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later.

H. Should Contractor create a Federal or State audit exception during the course of the provision of services under this agreement, due to an error or errors of omission or commission, Contractor shall be responsible for the audit exception and any associated recoupment. Should a Contractor-caused audit exception result in financial recoupment, County shall invoice Contractor for the associated amount and Contractor shall reimburse County the full amount within 30 days. The County will not offset future billings for repayment under this agreement.

I. All provisions in this section shall survive the termination, expiration, or cancellation of this agreement.

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V. Contract Amendments

Contractor and County may mutually agree, in writing, to amend the rates and/or services in this contract at the beginning of each fiscal year during the term of this contract.

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Exhibit B

COUNTY OF SISKIYOU
Behavioral Health Division
Health and Human Services Agency

Provider Manual for Specialty Mental Health Services

Revised August 4, 2021

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ATTACHMENTS

1. Quality Assurance Documentation Manual
2. Therapeutic Behavioral Services Documentation Manual
3. Siskiyou County Behavioral Health Services Incident Report Form
4. ADMIN 13-14 Change of Provider; and form
5. ADMIN 13-17 Beneficiary Problem Resolution Process policy and procedure; brochure; and form
6. ADMIN 15-01 Notice of Adverse Benefit Determination policy and procedure
7. ADMIN 16-05 Provider Selection Certification and Credentialing policy and procedure
8. CLIN 16-06 Progress Notes and Late Entry Documentation policy and procedure
9. CLIN 16-11 Medical Necessity Criteria policy and procedure
10. CLIN 300 Access, Assessment, and Treatment Planning for In-network and Out-of-Network Providers
11. CLIN 301 Clinical Screening and Assessment policy and procedure

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12. CLIN 302 Service Authorization Request policy and procedure, and form

13. CLIN 303 Access to Services Standards policy and procedure

14. CLIN 305 Specialty Mental Health Service Provision Standards

15. CLIN 307 Continuity of Care

16. CLIN 310 Authorization of Specialty Mental Health Services

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INTRODUCTION

Siskiyou County Health and Human Services Agency (SCHHSA) and its managed care entity, the Behavioral Health Division (BHD), is a public agency that recognizes the impact of emotional illness, maladaptive behavior and addiction upon individuals and the social fabric of our community. BHD is dedicated to providing an integrated array of services that encourage informed choices, support individual values and strengths, and provide opportunities for quality living.

In pursuit of this goal, BHD seeks to:

- Provide the highest quality behavioral healthcare in the most effective and efficient manner possible;
- Provide education, prevention, treatment and outreach for individuals requesting or requiring services;
- Promote ongoing recovery and emotional and mental well-being and stability;
- Value all individuals by treating them with kindness, respect for their right to self-determination, and respect for cultural values, traditions and differences;
- Extend behavioral health services to public agencies and communities through consultation, prevention and education;
- Implement policies and procedures and comply with all regulations in a manner that facilitates the most effective and efficient provision of services.

The Behavioral Health Division provides services to all Medi-Cal eligible residents of Siskiyou County who request services and who meet medical necessity criteria. All beneficiaries receiving services will be treated fairly, equally, and in a culturally competent manner.

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BACKGROUND

In 1991, California committed to a large-scale expansion of managed care service delivery models through Assembly Bill 336. This bill mandated that Medi-Cal programs promote efforts to arrange and encourage access to healthcare through entry into organized managed care plans available to the general public. In 1992, Senate Bill 485 directed the State Department of Health Services to expand implementation of Medi-Cal managed care. In 1994, Assembly Bill 757 established plans for Medi-Cal managed mental health care.

The County of Siskiyou Board of Supervisors endorsed the transfer of funds from the state for the implementation of the inpatient component (phase I) of a Medi-Cal managed mental healthcare system in Siskiyou County, which began on January 1, 1995. Phase II, the outpatient component, began on January 1, 1998.

SPECIALTY MENTAL HEALTH SERVICES (SMHS) CARVE-OUT

As a result of Medi-Cal phase II consolidation, which took effect in Siskiyou County on January 1, 1998, all non-hospital Medi-Cal specialty mental health services are administered and provided by the Behavioral Health Division. Medi-Cal beneficiaries previously seen in the Short-Doyle/ Medi-Cal system and those previously seen in the fee-for-service Medi-Cal system are now served by this entity.

The carve-out for mental health services does not include all mental health services that were previously delivered through the fee-for-service Medi-Cal program. The California Department of Mental Health determined medical necessity criteria. These criteria identify included and excluded diagnoses and services. The Medi-Cal eligible individual with an excluded diagnosis or who requires excluded services may continue to be provided with such services. These services are provided and billed through the Medi-Cal Managed Care Plans (MCPs) and the state administered fee-for-service Medi-Cal health program. These include services to treat mild to moderate mental health issues, substance abuse services, private psychologist/psychiatric provider services for beneficiaries who have both Medi-Cal and Medicare, and services for beneficiaries with cognitive and organic brain disorders. Mental health services delivered by primary care providers are not part of the mental health carve-out for specialty mental health services.

To avoid confusion, note that the phrase “outpatient specialty mental health services” refers to costs and services that are not directly attributable to a hospital or facility. Costs for professional services provided during the course of an inpatient or residential stay are considered outpatient “non-hospital services” for this purpose and are thus governed by the policies and procedures contained in this provider manual and Attachments 1-15.

The consolidation of the fee-for-service and Short-Doyle Medi-Cal systems for mental health services creates a context in which it is essential that all mental health services, whether inpatient, outpatient, clinical or rehabilitative, are viewed as components of an array of services designed to care for adults with mental illness, and children and

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adolescents with serious emotional disturbances. This system of care assumes a collaborative partnership between beneficiaries, family members and all service providers, all working to achieve the consumer's desired outcome in a cost-effective and clinically efficient manner. The medical necessity criteria for specialty mental health services are delineated in Attachment 8.

DESCRIPTION OF THE BENEFICIARY

The beneficiary of services by the Behavioral Health Division is defined as a person certified eligible for Medi-Cal who resides in Siskiyou County.

DESCRIPTION OF THE BENEFIT

All beneficiaries of BHD are eligible for a screening by BHD's or authorized contract provider access team to determine medical necessity for specialty mental health services (see Attachment 8: CLIN 16-11 Medical Necessity Criteria policy and procedure). Screenings may be conducted via telephone, telehealth or face-to-face. The initial or subsequent screening or assessment may determine:

1) Medical necessity for some level of specialty mental health service, or
2) No medical necessity for initial or additional specialty mental health services. In this case, the beneficiary will receive a referral to Partnership HealthPlan of California (PHC), the Medi-Cal managed care plan serving Siskiyou County, or other appropriate county or community human service resources. The beneficiary will also be given a Medi-Cal Notice of Adverse Benefit Determination (NOABD) form explaining why specialty mental health services have been denied (see page 14 and Attachment 5 for details).

When medical necessity for some level of specialty mental health services is determined to be present, benefits are limited to those clinically appropriate services which are authorized by BHD. There is a continuous quality management feedback loop in place which assesses the need for additional services and oversees authorization of treatment as necessary.

TREATMENT AUTHORIZATION PROCESS

In all situations, it is the intent of BHD to ensure that the beneficiary is referred to the appropriate level and type of service offered within the BHD array of services, or to the community. Access team staff will determine medical necessity for all beneficiaries using:

- The medical necessity criteria established for adults and for children by the Department of Health Care Services (see Attachment 8);
- Child and Adults Needs and Strengths Assessment (CANSA); and
- Presenting symptoms and behaviors.

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By regulations established in CCR Title IX, Chapter 11, all BHD authorization decisions will be made by licensed or wavered/registered mental health professionals.

AUTHORIZATION OF SPECIALITY MENTAL HEALTH SERVICES

The Behavioral Health Division is committed to ensuring beneficiaries have appropriate access to SMHS. Authorization and utilization management of services provided by the BHD adhere to the following principles:

- Are based on SMHS medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes;
- Are developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;
- Are evaluated, and updated if necessary, at least annually; and
- Are disclosed to the BHD's beneficiaries and network providers.

BHD shall not require prior authorization in the event that an organizational provider conducts an assessment, however, prior to the commencement of services, BHD's Quality Assurance Manager (QAM) or designee shall review and approve the beneficiaries' completed assessment and Client Plan. This approval serves as the authorization for services as outlined/identified in the client plan. Assessments and Client Plans completed by organizational providers may be faxed to 530-841-4702.

BHD requires prior authorization or referral for the following services:

- Intensive Home Based Services
- Day Treatment Intensive
- Day Rehabilitation
- Therapeutic Behavioral Services
- Therapeutic Foster Care

Initial authorization for these services will be provided by referral on the Service Authorization Request (SAR) form and shall specify the amount, scope and duration of the treatment BHD has authorized. All authorizations will be completed by a Licensed Professional of the Healing Arts (LPHA). Prior to the expiration of the initial authorization period, BHD requires organizational providers to request payment authorization for the continuation of services (see Attachment 15: CLIN 310 Authorization of Specialty Mental Health Services). BHD shall document all authorizations on the SAR Log.

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If BHD denies or modifies an authorization request, notification will be given to the beneficiary, in writing, of the adverse benefit determination prior to services being discontinued. Notification of adverse benefit decisions shall follow guidelines outlined in Attachment 5: ADMIN 15-01.

All SMHS requiring authorization will be authorized for providers using the SAR form (see Attachment 11: CLIN 302 Service Authorization Request policy and form). This attachment also includes a description of the screening and referral process.

1) Authorization of Outpatient Services

Service authorizations must be documented on the SAR form. Services requiring preauthorization provided to beneficiaries without authorization will not be reimbursed. Services that continue beyond the expiration of the authorization will not be reimbursed.

2) Determination of Eligibility

Each service authorization guarantees the full-scope Medi-Cal beneficiary eligibility only for the date the authorization was given. It does not guarantee ongoing Medi-Cal eligibility. It is the provider's responsibility to ensure that services are provided to eligible full-scope Medi-Cal beneficiaries. Providers may call BHD for assistance in verification of eligibility at any time during normal business hours.

3) Shared Clients

Medical necessity drives the process when a beneficiary requires intensive care coordination (ICC), intensive home-based services (IHBS), therapeutic foster care (TFC), therapeutic behavioral services (TBS), rehabilitation or inpatient hospitalization, demonstrating a higher level of acuity.
Services for the beneficiary will be provided in collaboration with the Children's System of Care (CSOC) supervisor for oversight and coordination of care.
Beneficiaries receiving distinct services by provider and BHD require regular case consultation and communication. This includes information regarding changes in engagement, treatment, medical necessity or diagnosis.

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4) Continuity of Care

Medi-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to BHD will be given the option to continue treatment for up to 12 months with an out- of-network Medi-Cal provider or a terminated network provider (i.e., and employee of BHD or a contracted organizational or network provider). SMHS will continue to be provided, at the request of the beneficiary, for a period of time not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by BHD in consultation with the beneficiary and the provider, and consistent with good professional practice (see Attachment 14: CLIN 307 Continuity of Care).

5) Aftercare Services

Upon discharge from hospitalization, outpatient SMHS follow-up to beneficiary will be provided within seven (7) days. Provider will submit re-assessment and all relevant documentation to CSOC supervisor, who will authorize the appropriate level of service for the beneficiary, which may or may not include re-authorization of services by a provider.

6) Consumer Financial Responsibility

When reimbursement for services is reduced or denied, the BHD beneficiary cannot be held financially responsible for the reduced or denied service cost.

Therapeutic Behavioral Services (TBS)

1) Definition

Therapeutic Behavioral Services are defined as one-to-one therapeutic contacts between a mental health provider and a beneficiary for a short-term period that are designed to maintain the
child/youth's placement at the lowest appropriate level of care by resolving target behaviors and achieving short-term goals. TBS may be provided in the community, home, educational setting, or at the beneficiary's residential placement.

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2) Authorization

TBS will be pre-authorized on a case-by-case basis using the SAR form, for a specific number of visits per authorization as established on the SAR and in the TBS treatment plan for the client. Treatment plans are developed by the treatment team and authorized by the appropriate BHD supervisor or administrator. TBS treatment plans will be reviewed and revised on at least a monthly basis. Services will be re-authorized based on the amended plan (See Attachment 15: CLIN 310 Authorization of Specialty Mental Health Services).

3) Timeliness

The provider shall provide an initial TBS visit within 3 working days of receipt of the referral.

4) Documentation

Health records documentation will be in accordance with BHD's Quality Assurance Documentation Manual, Attachment 1, and the TBS Documentation Manual, Attachment 2. When a closing is completed by the provider, the form and closing progress note must be faxed to the CSOC supervisor within 3 working days.

5) Incident Reporting

TBS providers will institute procedures to ensure that all occurrences of actual or potential harm and/or allegations of verbal and/or physical insult, injury or harm between and/or among beneficiaries, caregivers, and/or providers are documented on a county incident report form.
Please call the compliance officer at 530-841-4805 and fax the incident report to BHD at 530-841- 4712 within 24 hours of the event (see contact section on page 16). Siskiyou County's policy and procedure and incident reporting form can be found in Attachment 3.

6) Qualifications and Supervision of Therapeutic Behavioral Aides

Provider’s employees serving in the role of therapeutic behavioral aide will possess a bachelor’s degree and four years of experience in a mental health setting; up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years post associate of arts degree of experience may be substituted for the required bachelor’s degree, in addition to the requirement of four years’ experience in a mental health setting.

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The contractor shall provide and document supervision of TBAs by a LPHA in the ratio of 1 hour for every 40 hours worked.

FEE SCHEDULE

A fee schedule, indicating the amounts paid to organizational providers by BHD for covered services, is negotiated with each provider and included in the Behavioral Health Division's contract with the provider.

PAYMENT POLICIES AND PROCEDURES

1) Payment will be made for valid claims for outpatient specialty mental health services if:

   a) Services requiring preauthorization are authorized on a SAR form signed by a BHD supervisor or administrator. Be aware that services are not authorized retrospectively; and

   b) The services were delivered by a provider within her or his scope of practice and were within the range of the authorized service functions; and

   c) The services were provided to an eligible full-scope Medi-Cal beneficiary. After initial authorization by BHD, it is the provider's responsibility to determine ongoing eligibility of the beneficiary; and

   d) The documentation complies with the requirements laid out in Attachment 1: Quality Assurance Documentation Manual.

2) Claims will be paid for direct service provision, travel time to and from the assignment under specified guidelines, and documentation time.

3) Payment requests for all services are to be submitted as follows:

   a) All claims will be submitted using a HCFA 1500 form or a BHD acceptable format and with proper codes (see appendix A for Organizational Provider Key Guide). Each HCFA 1500 form or BHD acceptable format must contain charges for one month only. For example, charges for both June and July may not be included on the same HCFA 1500 form or BHD acceptable format but must be written on two separate forms. See appendix B for a sample of the Individual Service Activity Log required for claims.

   b) Progress notes for each date shown on the HCFA 1500 form or BHD acceptable format will be attached.

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An invoice/statement will be submitted along with the HCFA 1500 forms or BHD acceptable format and progress notes. This will show the total amount charged per client as well as a total for all clients. EXAMPLE:

Client	Total Minutes	Total Charge
Smith, John	320	$320.00
Doe, Jane	200	$200.00

TOTAL AMOUNT BILLED: $520.00

4) All claims for services, with supporting documentation attached, will be verified for accuracy and for proper authorization. The progress notes, dates and times will be checked against the HCFA 1500 form or BHD acceptable format. If there are any discrepancies, the invoice/statement will be adjusted. The HCFA 1500 form(s) or BHD acceptable format with the discrepancy will be returned to the provider along with the original progress note. After the provider makes the necessary corrections, a new or corrected HCFA 1500 form or BHD acceptable format, a new invoice/statement, and progress notes for the HCFA 1500 form will be sent to BHD fiscal services for processing.

5) Please send all requests for payment to:

Outpatient Claims Payment
County of Siskiyou
Behavioral Health Division
2060 Campus Drive
Yreka, CA 96097

6) BHD accounts payable are paid by the Siskiyou County Auditor's office. Claims filed by providers will be processed by BHD and submitted to the auditor's office for payment by a BHD fiscal technician.

7) In the event of an incorrect or disputed payment, the provider may contact the accounts payable fiscal technician, or the administrative services manager to resolve issues and errors. If a satisfactory resolution is not reached, the provider may file a written appeal within 30 days of receipt of the payment or notice of disallowance, with the BHD quality assurance manager.

8) BHD bills the Department of Health Care Services for Federal Financial Participation (FFP), using the language and codes of mental health service functions, as defined under the Medi-Cal rehabilitation option in Title IX.

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9) If verbal authorization is given, within five days thereafter, the provider will be informed in writing of the length of service, number of minutes, type of services and service codes that have been preauthorized. The subsequent claim must be submitted using these pre-authorized service codes. Claims submitted using service codes other than those authorized will be denied.

24-HOUR PHONE ACCESS WITH LINGUISTIC CAPABILITY

In accordance with state requirements, BHD maintains a statewide 24-hour toll free telephone number. Service is provided under contract with Crisis Support Services of Alameda County, which handles crisis calls after hours and holidays. During regular office hours, the BHD offices handle emergent and urgent calls and walk-ins. Phones are answered at all times by a live person. BHD also subscribes to Language Line services, which provides translators in over fifty languages and is available 24-hours a day.

Siskiyou County Behavioral Health Division's 24-hour toll free telephone number is: 1-800-842-8979

Urgent Conditions Out-Of-County

When an out-of-county individual is in need of urgent mental health services, any county mental health treatment staff or beneficiary may call the BHD 24-hour toll free telephone number for consultation and advisement.

PRIMARY CARE PHYSICIAN REQUESTS

Primary care physicians (PCP) may make referrals by calling the Behavioral Health main number at 530- 841-4100, or faxing a referral form to BHD's main office at 530-841-2799. The BHD access team will make decisions about the most appropriate consultative resources.

CONTRACT PROVIDER RESPONSIBILITIES

1) To assess BHD beneficiaries who inquire about receiving SMHS to determine eligibility.
2) To coordinate with the BHD for the provision of services to beneficiaries that meet medical necessity criteria for SMHS.
3) To provide BHD with all requested information within the established timelines in order to evaluate requests for re-authorization of services (see Attachment 11).
4) To accept all referrals from BHD, unless providers have notified BHD about the

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provider's temporary inability to accept new clients. This suspension of referrals will exist until the provider notifies BHD that new referrals will again be accepted.

5) Providers may refer beneficiaries back to BHD if the beneficiaries' needs are beyond the scope of the provider's ability to meet their request.

6) Pending completion of the assessment and treatment plan, provide only those services to BHD beneficiaries that are specified, authorized by BHD and allowable outside of a treatment plan. Authorized services may include, but are not limited to, mental health services (assessment, therapy, collateral, rehabilitation and plan development), medication support, therapeutic behavioral services, intensive care coordination, intensive home based services, and case management. Services are to be provided in no more than 2-hour increments without prior approval by a BHD supervisor. These are identified in each specific provider's contract.

7) To schedule an initial visit for therapeutic behavioral services within 3 business days of receipt of the referral; to schedule an initial visit within 10 business days of the receipt of the referral for all other services by BHD.

8) To inform the CSOC supervisor and the BHD crisis team and discuss with them any potential admission of a beneficiary into an inpatient hospital.

9) To provide services to BHD beneficiaries in accordance with legal and ethical standards as prescribed by all relevant professional, federal, state, and/or local regulatory and statutory requirements.

10) To maintain clinical records according to BHD and DHCS standards, and that are consistent with current policies and manuals contained in the attachments to this contract.

   a) Permit effective internal and external quality review and audit processes

   b) Technical assistance regarding documentation and billing requirements is available through BHD's quality assurance department (see contacts on page 16)

   c) All documentation of mental health services shall be co-signed by a LPHA. All providers must maintain charts according to BHD policies and procedures

11) To make the books and records which pertain to the services provided to beneficiaries under the provisions of the BHD contract available for inspection, examination or copying by BHD, the Department of Health Care Services, and the United States Department of Health and Human Services, and to maintain them at the provider's place of business or at another mutually agreeable location, and in a form in accordance with general health information standards.

12) To meet the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal, state and county laws, rules and regulations, and to work cooperatively with the staff who authorize and reauthorize clinical services.

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13) To dialogue with BHD quality management, compliance, administration, CSOC supervisor and clinical staff regularly to ensure smooth transitions of services, continuity of care, quality documentation and service delivery, program compliance, and provider relations.

14) To immediately report and fax written documents of all formal requests for problem resolution by a beneficiary or his/her guardian to the compliance officer (see contacts on page 16) and to explain the BHD problem resolution process to the beneficiary. See the beneficiary problem resolution process on page 13-14 and in Attachment 4.

15) To send out Notice of Adverse Beneficiary Determination letters when applicable per the policy and procedure in Attachment 5, and to fax a copy of the NOABD to the compliance officer.

NOTICES

If they affect the provider, notices will be mailed to contracted providers to keep them abreast of policy, administrative or financial changes. All changes to the BHD policy and procedure manuals that are noticed in provider communications have the authority of policy and are binding.

QUALITY MANAGEMENT

BHD's quality improvement work plan (QIWP) is designed to ensure that high quality services are provided to members in a cost-effective and efficient manner. The quality improvement committee (QIC) reviews the BHD services and contracted providers in order to ensure that services are accessible; are meaningful and beneficial to the client; are culturally and linguistically competent; produce highly desirable results through the efficient use of resources; and that documentation is being entered and maintained according to agency, state and federal standards. The QIC recommends corrective action and recommends quality improvements throughout the service continuum. Membership in the QIC is required for organizational providers within Siskiyou County.

BHD quality improvement staff and designee will monitor member satisfaction with the services received from organizational providers, and may evaluate contract performance based on the contract objectives. Providers may be asked to participate in focus group as a part of the Department of Health Care Services' external quality yearly review. Providers are encouraged to contact BHD's' quality assurance manager or compliance officer at any time with questions, comments, suggestions and training needs.

If the BHD finds that a provider is out-of-compliance with rendering or managing care, or if other problem areas are discovered, corrective sanctions may be applied. These sanctions may include mandatory review of all claims, periodic or focused review of health records, or termination of the provider's contract with BHD.

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Training

BHD quality improvement staff and designees provide training in medical necessity criteria, mental health documentation, beneficiary protection, cultural and linguistic competence, clinical service provision and other components of the QIWP. Providers are required to attend BHD's yearly mandatory trainings which include cultural competence trainings, law and ethics training and any mandatory compliance training which may impact a provider's services to clients. BHD will provide access to live, mandatory training opportunities. In the event that the required training is not available or the provider's staff member cannot attend BHD's training, than documentation in the form of certifications must be submitted to the compliance officer demonstrating attendance at training consistent with BHD's requirements.

BENEFICIARY PROBLEM RESOLUTION PROCESS

It is the goal of BHD to have a consumer-friendly process in place to allow for any situation in which a member may have a concern, request or complaint regarding any aspect of service. These procedures are known collectively as the *problem resolution process,* and include the grievance and appeal processes.

Tracking of the Problem Resolution Process

The compliance officer maintains a grievance and appeal log in order to track all beneficiary problem resolution requests. The log is reviewed by the QAM and an annual report is provided to the quality improvement committee. This process is used to identify and address systemic problems or weaknesses. The log is open to review by the Department of Health Care Services (DHCS), and the Center for Medicare and Medicaid Services (CMS). Annually, the BHD submits information on all grievances and appeals to DHCS. The compliance officer should be called immediately upon receipt of a beneficiary grievance, exempt grievance, request for appeal, expedited appeal and state fair hearing, and documents must be faxed to 530-841-2799. In addition, it is highly recommended that providers keep a log of all documents exchanged and contacts with BHD pertaining to the problem resolution process.

Provider Role in the Process

1) Beneficiaries referred to organizational providers, or their guardians may file a grievance orally or in writing with either the provider or BHD at any time. Grievances that are received over the telephone or in-person by BHD, or a contracted provider and are resolved to the beneficiary's satisfaction by close of the next business day following receipt are exempt from the requirement for BHD to send a written acknowledgment and disposition letter, but a written entry in the BHD grievance log is required for exempt grievances.

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2) The provider will make available to beneficiaries and their guardians a BHD grievance and appeals form, an envelope addressed to the BHD compliance officer, and a copy of the beneficiary brochure, *Client Rights and the Grievance Process*, which provides details of the process and contact information for BHD's patients' rights advocate as well as DHCS' ombudsman. Providers are asked to display these items in a public area and to contact the compliance officer (see contacts on page 16) whenever additional supplies are needed. The provider's employees should offer a beneficiary or her/his guardian the option of a formal problem resolution process and walk them through the process when a beneficiary or guardian has a grievance.

3) Providers must immediately call and fax written documents of all formal requests for problem resolution by a beneficiary or his/her guardian to the compliance officer (see contacts on page 16) and should explain the BHD problem resolution process to the beneficiary or request that BHD do so. BHD's compliance officer will coordinate the problem resolution process and BHD staff will investigate all grievances.

4) See Attachment 4 for details about BHD's beneficiary problem resolution process policy and procedure, the brochure, and a grievance and appeals form.

Change of Provider Requests

Whenever feasible and requested, beneficiaries have the right to choose from a list of qualified providers identified by the BHD. This includes the right to use culturally-specific providers. Providers will make available to clients requesting a change of provider (COP) the "Change of Provider Request Form" and resolve the request within 10 business days, following policy and procedure Admin13-14.

Provider will notify the compliance officer by faxing completed COP forms to 530-841-2799.

In the event that a COP is not able to be resolved by the provider, provider will notify the CSOC supervisor, who will then attempt to resolve the COP within the BHD network.

When a COP is received for a beneficiary currently engaged in a Continuity of Care agreement, the CSOC Supervisor or designee must be notified by the provider within 24 hours. The CSOC supervisor, or designee will resolve the request within 10 business days. If the beneficiary chooses to discontinue with the provider, the Continuity of Care Single Case Agreement is terminated, effective the date of COP resolution.

Notice of Adverse Beneficiary Determination (NOABD) and Appeals

Beneficiaries will be fully informed in writing and orally, if possible, and in their preferred language, of any of the following actions taken by BHD:

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1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2) The reduction, suspension, or termination of a previously authorized service;
3) The denial, in whole or in part, of payment for a service;
4) The failure to provide services in a timely manner;
5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6) The denial of a beneficiary's request to dispute financial liability.

Timing of the Notice: BHD will mail the notice to the beneficiary within the following timeframes:

1) For termination, suspension, or reduction of a previously authorized specialty mental health service, at least 10 days before the date of action, except as permitted under Title 42 Code of Federal Regulations, Sections 431.213 (Exceptions to advance notice) and 431.214 (Notices in cases of probable fraud);
2) For denial of payment, at the time of any action denying the provider's claim; or,
3) For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision.

This information will be received in the form of a Medi-Cal Notice of Adverse Benefit Determination (NOABD) form (see Attachment 5 for the NOABD policy and procedure). All appropriate efforts will be made to assist beneficiaries in preparing for the action, including, but not limited to, referral to alternate resources and support, such as the Beacon provider network, self-help groups and free community services, and the reason for the decision. Beneficiaries will be informed of their right to file an appeal with BHD and/or the beneficiary's right to file for a state fair hearing before an administrative law judge once they have exhausted the BHD appeals process.

Providers are required to send out NOABD letters in all circumstances per the NOABD policy and procedure in Attachment 5 and to fax a copy of the NOABD to the compliance officer (see contacts on page 16). For example, if the provider does not follow the timelines for providing services outlined in this manual, such as an initial visit for TBS within 3 working days, a NOABD must be sent.

Often, decisions regarding a beneficiary's admission to or continuance of services are made by the BHD access team and providers will not generally be required to issue NOABD forms to beneficiaries.
However, if during the course of working with a referred beneficiary, the provider determines that BHD should deny, change, reduce or terminate the beneficiary's

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services, the provider will send a request or recommendation to the CSOC supervisor. The CSOC supervisor will make a final determination and send a NOABD to the beneficiary when warranted.

Decisions regarding NOABDs will be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, BHD will also include the name and direct telephone number or extension of the decision- maker.

PROVIDER PROBLEM RESOLUTION PROCESS

The focal point of the problem resolution process for providers is BHD. A provider may access the BHD informal or formal problem resolution process any time there is a payment authorization or claims processing problem. Every effort will be made by BHD to resolve problems at the informal level. If the problem cannot be resolved at this level, the provider may appeal through the BHD formal grievance process. If the provider so desires, a formal grievance may be filed without first completing the informal complaint process. The BHD will work to resolve problems in a sensitive and timely manner.

Provider Informal Problem Resolution Process

1) Providers may address problems or suggestions informally to BHD at any time. This may be accomplished verbally or in writing to the BHD quality assurance manager.
2) The quality assurance manager will respond within 5 working days of the contact to resolve the concerns through discussions with the provider and any other BHD staff involved.
3) Providers may access the provider appeals process at any time before, during or after the provider informal problem resolution process has begun when the complaint concerns a denied or modified payment authorization request, the processing or payment of a provider's claim to BHD, or when accessing the provider problem resolution process will affect the provider's timelines for accessing the provider appeal process.

Provider Appeals Process: Service Reduction or Denial

1) When a SAR or a re-authorization is denied or modified, and the provider disputes this determination and files an appeal within 90 calendar days of notification of the denial or modification, the BHD clinical director or designee will review the appeal and respond in writing within 30 calendar days.

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Provider Appeals Process: Claims Payment

1) Providers who receive payment directly from BHD may file a written appeal concerning the denial or delay of claims payment to the BHD administrative services manager.
2) The written appeal must be received by the BHD administrative services manager within 90 calendar days of the date of receipt of the denial or delay of the claims payment.
3) The BHD administrative services manager will review the appeal and respond to the provider in writing with the result within 30 calendar days of the date of receipt of the appeal.
4) If the appeal is upheld or partial payment is approved, BHD will process the claim for payment within 14 calendar days.

Provider Appeals Process: Credentialing

1) If BHD reduces, suspends or terminates a licensed, waivered or registered provider's credentials due to the provider's failure to meet the credentialing or re-credentialing requirements as defined in BHD ADMIN 16-05, Provider Selection Certification and Credentialing (see Attachment 6), and state and federal credentialing requirements, the provider may file a written appeal to the BHD director.
2) The written appeal must be received by the BHD director within 90 calendar days of when the provider is notified of the reduction, suspension or termination of credentials.
3) The BHD director will review the appeal and respond to the provider in writing with the result within 30 calendar days of the date of receipt of the appeal.

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CONTACT INFORMATION

Siskiyou County Health and
Human Services Behavioral
Health Division
2060 Campus Drive
Yreka, CA 96097
Main Office Phone: (530) 841-4100 Fax: (530) 841-2799

We strive to provide technical assistance to providers on any aspect of the provider contract and welcome your questions.

The contact person for documentation, and all provider problems and appeals is: Ashley Bray, LPCC, Quality Assurance Manager
530-841-4161

The contact person for beneficiary problem resolution process, NOABDs, and staff training is: Dee Barton, Compliance Officer
530-841-4805

The contact person for claims payment procedures is: Rose Bullock, Administrative Services Manager
530-841-4732

The contact person for patients' rights is: Wendy Cheula, Patient's Rights Advocate 530-918-7202

The contact persons for Children's System of Care are:
Christine Gannon, LCSW Clinical Services Site Supervisor
530-841-4848
and
Aimee Von Tungeln, LMFT, Deputy Director
530-841-4809

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Exhibit “C”

ASSURANCE OF COMPLIANCE WITH THE SISKIYOU COUNTY HEALTH AND HUMAN SERVICES AGENCY – BEHAVIORAL HEALTH DIVISION NONDISCRIMINATION IN STATE AND FEDERALLY – ASSISTED PROGRAMS

CONTRACTOR HEREBY AGREES THAT it will comply with the nondiscrimination provisions of this contract as further described below and referenced in the California Department of Health Care Services Specialty Mental Health Services Agreement Exhibit E, Section 3 -

1) Consistent with the requirements of applicable federal law such as 42 C.F.R. §§ 438.6(d)(3) and (4) or state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical handicap. The Contractor will not discriminate against beneficiaries on the basis of health status or need for health care services, pursuant to 42 C.F.R. § 438.6(d)(3).

2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977.

Contractor agrees this assurance is binding on the vendor/recipient directly or through contract, license, or other provider services, as long as it received federal or state assistance.

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Exhibit “D”

BUSINESS ASSOCIATES AGREEMENT
UNDER THE HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996 (HIPAA)

Siskiyou County Health and Human Services Agency, Behavioral Health Division (“County”) is a Covered Entity as defined by, and subject to the requirements and prohibitions of, the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), and regulations promulgated thereunder, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164 (collectively, the "HIPAA Rules").

Contractor performs or provides functions, activities or services to County that require Contractor, in order to provide such functions, activities or services, to create, access, receive, maintain, and/or transmit information that includes or that may include Protected Health Information, as defined by the HIPAA Rules. As such, Contractor is a Business Associate as defined by the HIPAA Rules, and is therefore subject to those provisions of the HIPAA Rules that are applicable to Business Associates.

The HIPAA Rules require a written agreement ("Business Associate Agreement") between County and Contractor in order to mandate certain protections for the privacy and security of Protected Health Information, and these HIPAA Rules prohibit the disclosure to or use of Protected Health Information by Contractor if such an agreement is not in place.

This Business Associate Agreement and its provisions are intended to protect the privacy and provide for the security of Protected Health Information disclosed to or used by Contractor in compliance with the HIPAA Rules.

Therefore, the parties agree as follows:

1. DEFINITIONS

1.1 "Breach" has the same meaning as the term "breach" at 45 C.F.R. § 164.402.

1.2 "Business Associate" has the same meaning as the term "business associate" at 45 C.F.R. § 160.103. For the convenience of the parties, a "business associate" is a person or entity, other than a member of the workforce of covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to Protected Health Information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of another business associate. And in reference to the party to this Business Associate Agreement "Business Associate" shall mean Contractor.

1.3 "Covered Entity" has the same meaning as the term “covered entity” at 45 C.F.R. § 160.103, and in reference to the party to this Business Associate Agreement, "Covered Entity" shall mean Siskiyou County Health and Human Services Agency, Behavioral Health Division.

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1.4 "Data Aggregation" has the same meaning as the term "data aggregation" at 45 C.F.R. § 164.501.

1.5 "De-identification" refers to the de-identification standard at 45 C.F.R. § 164.514.

1.6 "Designated Record Set" has the same meaning as the term "designated record set" at 45 C.F.R. § 164.501.

1.7 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its workforce. (See 45 C.F.R. § 160.103.)

1.8 "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff. (See 42 U.S. C. § 17921.)

1.9 "Electronic Media" has the same meaning as the term "electronic media" at 45 C.F.R. § 160.103. For the convenience of the parties, electronic media means (1) Electronic storage material on which data is or may be recorded electronically, including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

1.10 "Electronic Protected Health Information" has the same meaning as the term "electronic protected health information" at 45 C.F.R. § 160.103, limited to Protected Health Information created or received by Business Associate from or on behalf of Covered Entity. For the convenience of the parties, Electronic Protected Health Information means Protected Health Information that is (i) transmitted by electronic media; (ii) maintained in electronic media.

1.11 "Health Care Operations" has the same meaning as the term "health care operations" at 45 C.F.R. § 164.501.

1.12 "Individual" has the same meaning as the term "individual" at 45 C.F.R. § 160.103. For the convenience of the parties, Individual means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502 (g).

1.13 "Law Enforcement Official" has the same meaning as the term "law enforcement official" at 45 C.F.R. § 164.103.

1.14 "Minimum Necessary" refers to the minimum necessary standard at 45 C.F.R. § 162.502 (b).

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1.15 “Protected Health Information” has the same meaning as the term “protected health information” at 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. For the convenience of the parties, Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity, and includes Protected Health Information that is made accessible to Business Associate by Covered Entity. “Protected Health Information” includes Electronic Protected Health Information.

1.16 “Required by Law” " has the same meaning as the term "required by law" at 45 C.F.R. § 164.103.

1.17 "Secretary" has the same meaning as the term "secretary" at 45 C.F.R. § 160.103

1.18 "Security Incident” has the same meaning as the term "security incident" at 45 C.F.R. § 164.304.

1.19 "Services” means, unless otherwise specified, those functions, activities, or services in the applicable underlying Agreement, Contract, Master Agreement, Work Order, or Purchase Order or other service arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

1.20 "Subcontractor" has the same meaning as the term "subcontractor" at 45 C.F.R. § 160.103.

1.21 "Unsecured Protected Health Information" has the same meaning as the term “unsecured protected health information" at 45 C.F.R. § 164.402.

1.22 “Use” or “Uses” means, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate’s internal operations. (See 45 C.F.R § 164.103.)

1.23 Terms used, but not otherwise defined in this Business Associate Agreement, have the same meaning as those terms in the HIPAA Rules.

2. PERMITTED AND REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

2.1 Business Associate may only Use and/or Disclose Protected Health Information as necessary to perform Services, and/or as necessary to comply with the obligations of this Business Associate Agreement.

2.2 Business Associate may Use Protected Health Information for de-identification of the information if de-identification of the information is required to provide Services.

2.3 Business Associate may Use or Disclose Protected Health Information as Required by Law.

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2.4 Business Associate shall make Uses and Disclosures and requests for Protected Health Information consistent with the Covered Entity's applicable Minimum Necessary policies and procedures.

2.5 Business Associate may Use Protected Health Information as necessary for the proper management and administration of its business or to carry out its legal responsibilities.

2.6 Business Associate may Disclose Protected Health Information as necessary for the proper management and administration of its business or to carry out its legal responsibilities, provided the Disclosure is Required by Law or Business Associate obtains reasonable assurances from the person to whom the Protected Health Information is disclosed (i.e., the recipient) that it will be held confidentially and Used or further Disclosed only as Required by Law or for the purposes for which it was disclosed to the recipient and the recipient notifies Business Associate of any instances of which it is aware in which the confidentiality of the Protected Health Information has been breached.

2.7 Business Associate may provide Data Aggregation services relating to Covered Entity's Health Care Operations if such Data Aggregation services are necessary in order to provide Services.

3. PROHIBITED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

3.1 Business Associate shall not Use or Disclose Protected Health Information other than as permitted or required by this Business Associate Agreement or as Required by Law.

3.2 Business Associate shall not Use or Disclose Protected Health Information in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except for the specific Uses and Disclosures set forth in Sections 2.5 and 2.6.

3.3 Business Associate shall not Use or Disclose Protected Health Information for de-identification of the information except as set forth in section 2.2.

4. OBLIGATIONS TO SAFEGUARD PROTECTED HEALTH INFORMATION

4.1 Business Associate shall implement, use, and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information other than as provided for by this Business Associate Agreement.

4.2 Business Associate shall comply with Subpart C of 45 C.F.R Part 164 with respect to Electronic Protected Health Information, to prevent the Use or Disclosure of such information other than as provided for by this Business Associate Agreement.

5. REPORTING NON-PERMITTED USES OR DISCLOSURES, SECURITY INCIDENTS, AND BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION

5.1 Business Associate shall report to Covered Entity any Use or Disclosure of Protected Health Information not permitted by this Business Associate Agreement, any Security

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Incident, and/ or any Breach of Unsecured Protected Health Information as further described in Sections 5.1.1, 5.1.2, and 5.1.3.

5.1.1 Business Associate shall report to Covered Entity any Use or Disclosure of Protected Health Information by Business Associate, its employees, representatives, agents or Subcontractors not provided for by this Agreement of which Business Associate becomes aware.

5.1.2 Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

5.1.3. Business Associate shall report to Covered Entity any Breach by Business Associate, its employees, representatives, agents, workforce members, or Subcontractors of Unsecured Protected Health Information that is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Breach of Unsecured Protected Health Information if the Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of Business Associate, including a Subcontractor, as determined in accordance with the federal common law of agency.

5.2 Except as provided in Section 5.3, for any reporting required by Section 5.1, Business Associate shall provide, to the extent available, all information required by, and within the times frames specified in, Sections 5.2.1 and 5.2.2.

5.2.1 Business Associate shall make an immediate telephonic report upon discovery of the non-permitted Use or Disclosure of Protected Health Information, Security Incident or Breach of Unsecured Protected Health Information to **(562) 940-3335** that minimally includes:

(a) A brief description of what happened, including the date of the non-permitted Use or Disclosure, Security Incident, or Breach and the date of Discovery of the non-permitted Use or Disclosure, Security Incident, or Breach, if known;

(b) The number of Individuals whose Protected Health Information is involved;

(c) A description of the specific type of Protected Health Information involved in the non-permitted Use or Disclosure, Security Incident, or Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved);

(d) The name and contact information for a person highly knowledge of the facts and circumstances of the non-permitted Use or Disclosure of PHI, Security Incident, or Breach

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5.2.2 Business Associate shall make a written report without unreasonable delay and in no event later than three (3) business days from the date of discovery by Business Associate of the non-permitted Use or Disclosure of Protected Health Information, Security Incident, or Breach of Unsecured Protected Health Information and to the **Health and Human Services Agency Privacy Officer at: Dee Barton, Privacy Officer, Siskiyou County Health and Human Services Agency, 2060 Campus Drive, Yreka, CA 96097, dbarton1@co.siskiyou.ca.us, Phone: (530) 841-4805, Fax: (530) 841-4799,** that includes, to the extent possible:

(a) A brief description of what happened, including the date of the non-permitted Use or Disclosure, Security Incident, or Breach and the date of Discovery of the non-permitted Use or Disclosure, Security Incident, or Breach, if known;

(b) The number of Individuals whose Protected Health Information is involved;

(c) A description of the specific type of Protected Health Information involved in the non-permitted Use or Disclosure, Security Incident, or Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved);

(d) The identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, Used, or Disclosed;

(e) Any other information necessary to conduct an assessment of whether notification to the Individual(s) under 45 C.F.R. § 164.404 is required;

(f) Any steps Business Associate believes that the Individual(s) could take to protect him or herself from potential harm from the non-permitted Use or Disclosure, Security Incident, or Breach;

(g) A brief description of what Business Associate is doing to investigate, to mitigate harm to the Individual(s), and to protect against any further similar occurrences; and

(h) The name and contact information for a person highly knowledge of the facts and circumstances of the non-permitted Use or Disclosure of PHI, Security Incident, or Breach.

5.2.3 If Business Associate is not able to provide the information specified in Section 5.2.1 or 5.2.2 at the time of the required report, Business Associate shall provide such information promptly thereafter as such information becomes available.

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5.3 Business Associate may delay the notification required by Section 5.1.3, if a law enforcement official states to Business Associate that notification would impede a criminal investigation or cause damage to national security.

5.3.1 If the law enforcement official's statement is in writing and specifies the time for which a delay is required, Business Associate shall delay its reporting and/or notification obligation(s) for the time period specified by the official.

5.3.2 If the statement is made orally, Business Associate shall document the statement, including the identity of the official making the statement, and delay its reporting and/or notification obligation(s) temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described in Section 5.3.1 is submitted during that time.

6. WRITTEN ASSURANCES OF SUBCONTRACTORS

6.1 In accordance with 45 C.F.R. § 164.502 (e)(1)(ii) and § 164.308 (b)(2), if applicable, Business Associate shall ensure that any Subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of Business Associate is made aware of its status as a Business Associate with respect to such information and that Subcontractor agrees in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information.

6.2 Business Associate shall take reasonable steps to cure any material breach or violation by Subcontractor of the agreement required by Section 6.1.

6.3 If the steps required by Section 6.2 do not cure the breach or end the violation, Contractor shall terminate, if feasible, any arrangement with Subcontractor by which Subcontractor creates, receives, maintains, or transmits Protected Health Information on behalf of Business Associate.

6.4 If neither cure nor termination as set forth in Sections 6.2 and 6.3 is feasible, Business Associate shall immediately notify CalMHSA.

6.5 Without limiting the requirements of Section 6.1, the agreement required by Section 6.1 (Subcontractor Business Associate Agreement) shall require Subcontractor to contemporaneously notify Covered Entity in the event of a Breach of Unsecured Protected Health Information.

6.6 Without limiting the requirements of Section 6.1, agreement required by Section 6.1 (Subcontractor Business Associate Agreement) shall include a provision requiring Subcontractor to destroy, or in the alternative to return to Business Associate, any Protected Health Information created, received, maintained, or transmitted by Subcontractor on behalf of Business Associate so as to enable Business Associate to comply with the provisions of Section 18.4.

6.7 Business Associate shall provide to Covered Entity, at Covered Entity's request, a copy of any and all Subcontractor Business Associate Agreements required by Section 6.1.

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6.8 Sections 6.1 and 6.7 are not intended by the parties to limit in any way the scope of Business Associate's obligations related to Subcontracts or Subcontracting in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

7. ACCESS TO PROTECTED HEALTH INFORMATION

7.1 To the extent Covered Entity determines that Protected Health Information is maintained by Business Associate or its agents or Subcontractors in a Designated Record Set, Business Associate shall, within two (2) business days after receipt of a request from Covered Entity, make the Protected Health Information specified by Covered Entity available to the Individual(s) identified by Covered Entity as being entitled to access and shall provide such Individuals(s) or other person(s) designated by Covered Entity with a copy the specified Protected Health Information, in order for Covered Entity to meet the requirements of 45 C.F.R. § 164.524.

7.2 If any Individual requests access to Protected Health Information directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within two (2) days of the receipt of the request. Whether access shall be provided or denied shall be determined by Covered Entity.

7.3 To the extent that Business Associate maintains Protected Health Information that is subject to access as set forth above in one or more Designated Record Sets electronically and if the Individual requests an electronic copy of such information, Business Associate shall provide the Individual with access to the Protected Health Information in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by Covered Entity and the Individual.

8. AMENDMENT OF PROTECTED HEALTH INFORMATION

8.1 To the extent Covered Entity determines that any Protected Health Information is maintained by Business Associate or its agents or Subcontractors in a Designated Record Set, Business Associate shall, within ten (10) business days after receipt of a written request from Covered Entity, make any amendments to such Protected Health Information that are requested by Covered Entity, in order for Covered Entity to meet the requirements of 45 C.F.R. § 164.526.

8.2 If any Individual requests an amendment to Protected Health Information directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within five (5) days of the receipt of the request. Whether an amendment shall be granted or denied shall be determined by Covered Entity.

9. ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

9.1 Business Associate shall maintain an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or Subcontractors, as is determined by Covered Entity to be necessary in order to permit Covered Entity to respond to a request by an Individual

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for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

9.1.1 Any accounting of disclosures provided by Business Associate under Section 9.1 shall include:

(a) The date of the Disclosure;

(b) The name, and address if known, of the entity or person who received the Protected Health Information;

(c) A brief description of the Protected Health Information Disclosed; and

(d) A brief statement of the purpose of the Disclosure.

9.1.2 For each Disclosure that could require an accounting under Section 9.1, Business Associate shall document the information specified in Section 9.1.1, and shall maintain the information for six (6) years from the date of the Disclosure.

9.2 Business Associate shall provide to Covered Entity, within ten (10) business days after receipt of a written request from Covered Entity, information collected in accordance with Section 9.1.1 to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528

9.3 If any Individual requests an accounting of disclosures directly from Business Associate or its agents or Subcontractors, Business Associate shall notify Covered Entity in writing within five (5) days of the receipt of the request, and shall provide the requested accounting of disclosures to the Individual(s) within 30 days. The information provided in the accounting shall be in accordance with 45 C.F.R. § 164.528.

10. COMPLIANCE WITH APPLICABLE HIPAA RULES

10.1 To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity's performance of such obligation(s).

10.2 Business Associate shall comply with all HIPAA Rules applicable to Business Associate in the performance of Services.

11. AVAILABILITY OF RECORDS

11.1 Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity available to the Secretary for purposes of determining Covered Entity’s compliance with the Privacy and Security Regulations.

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11.2 Unless prohibited by the Secretary, Business Associate shall immediately notify Covered Entity of any requests made by the Secretary and provide Covered Entity with copies of any documents produced in response to such request.

12. MITIGATION OF HARMFUL EFFECTS

12.1 Business Associate shall mitigate, to the extent practicable, any harmful effect of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Business Associate Agreement that is known to Business Associate.

13. BREACH NOTIFICATION TO INDIVIDUALS

13.1 Business Associate shall, to the extent Covered Entity determines that there has been a Breach of Unsecured Protected Health Information by Business Associate, its employees, representatives, agents or Subcontractors, provide breach notification to the Individual in a manner that permits Covered Entity to comply with its obligations under 45 C.F.R. § 164.404.

13.1.1 Business Associate shall notify, subject to the review and approval of Covered Entity, each Individual whose Unsecured Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, Used, or Disclosed as a result of any such Breach.

13.1.2 The notification provided by Business Associate shall be written in plain language, shall be subject to review and approval by Covered Entity, and shall include, to the extent possible:

(a) A brief description of what happened, including the date of the Breach and the date of the Discovery of the Breach, if known;

(b) A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(c) Any steps the Individual should take to protect him or herself from potential harm resulting from the Breach;

(d) A brief description of what Business Associate is doing to investigate the Breach, to mitigate harm to Individual(s), and to protect against any further Breaches; and

(e) Contact procedures for Individual(s) to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

13.2 Covered Entity, in its sole discretion, may elect to provide the notification required by Section 13.1 and/or to establish the contact procedures described in Section 13.1.2.

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13.3 Business Associate shall reimburse Covered Entity any and all costs incurred by Covered Entity, in complying with Subpart D of 45 C.F.R. Part 164, including but not limited to costs of notification, internet posting, or media publication, as a result of Business Associate's Breach of Unsecured Protected Health Information; Covered Entity shall not be responsible for any costs incurred by Business Associate in providing the notification required by 13.1 or in establishing the contact procedures required by Section 13.1.2.

14. INDEMNIFICATION

14.1 Business Associate shall indemnify, defend, and hold harmless Covered Entity, its Special Districts, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, expenses (including attorney and expert witness fees), and penalties and/or fines (including regulatory penalties and/or fines), arising from or connected with Business Associate's acts and/or omissions arising from and/or relating to this Business Associate Agreement, including, but not limited to, compliance and/or enforcement actions and/or activities, whether formal or informal, by the Secretary or by the Attorney General of the State of California.

14.2 Section 14.1 is not intended by the parties to limit in any way the scope of Business Associate's obligations related to Insurance and/or Indemnification in the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

15. OBLIGATIONS OF COVERED ENTITY

15.1 Covered Entity shall notify Business Associate of any current or future restrictions or limitations on the Use or Disclosure of Protected Health Information that would affect Business Associate’s performance of the Services, and Business Associate shall thereafter restrict or limit its own Uses and Disclosures accordingly.

15.2 Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in any manner that would not be permissible under Subpart E of 45 C.F.R. Part 164 if done by Covered Entity, except to the extent that Business Associate may Use or Disclose Protected Health Information as provided in Sections 2.3, 2.5, and 2.6.

16. TERM

16.1 Unless sooner terminated as set forth in Section 17, the term of this Business Associate Agreement shall be the same as the term of the applicable underlying Agreement, Contract, Participation Agreement, Master Agreement, Work Order, Purchase Order, or other service arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

16.2 Notwithstanding Section 16.1, Business Associate’s obligations under Sections 11, 14, and 18 shall survive the termination or expiration of this Business Associate Agreement.

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17. TERMINATION FOR CAUSE

17.1 In addition to and notwithstanding the termination provisions set forth in the applicable underlying Agreement, Contract, Participation Agreement, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, if either party determines that the other party has violated a material term of this Business Associate Agreement, and the breaching party has not cured the breach or ended the violation within the time specified by the non-breaching party, which shall be reasonable given the nature of the breach and/or violation, the non-breaching party may terminate this Business Associate Agreement.

17.2 In addition to and notwithstanding the termination provisions set forth in the applicable underlying Agreement, Contract, Participation Agreement, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, if either party determines that the other party has violated a material term of this Business Associate Agreement, and cure is not feasible, the non-breaching party may terminate this Business Associate Agreement immediately.

18. DISPOSITION OF PROTECTED HEALTH INFORMATION UPON TERMINATION OR EXPIRATION

18.1 Except as provided in Section 18.3, upon termination for any reason or expiration of this Business Associate Agreement, Business Associate shall return or, if agreed to by Covered entity, shall destroy as provided for in Section 18.2, all Protected Health Information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that Business Associate, including any Subcontractor, still maintains in any form. Business Associate shall retain no copies of the Protected Health Information.

18.2 Destruction for purposes of Section 18.2 and Section 6.6 shall mean that media on which the Protected Health Information is stored or recorded has been destroyed and/or electronic media have been cleared, purged, or destroyed in accordance with the use of a technology or methodology specified by the Secretary in guidance for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals.

18.3 Notwithstanding Section 18.1, in the event that return or destruction of Protected Health Information is not feasible or Business Associate determines that any such Protected Health Information is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities, Business Associate may retain that Protected Health Information for which destruction or return is infeasible or that Protected Health Information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities and shall return or destroy all other Protected Health Information.

18.3.1 Business Associate shall extend the protections of this Business Associate Agreement to such Protected Health Information, including continuing to use appropriate safeguards and continuing to comply with Subpart C of 45 C.F.R

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Part 164 with respect to Electronic Protected Health Information, to prevent the Use or Disclosure of such information other than as provided for in Sections 2.5 and 2.6 for so long as such Protected Health Information is retained, and Business Associate shall not Use or Disclose such Protected Health Information other than for the purposes for which such Protected Health Information was retained.

18.3.2 Business Associate shall return or, if agreed to by Covered entity, destroy the Protected Health Information retained by Business Associate when it is no longer needed by Business Associate for Business Associate's proper management and administration or to carry out its legal responsibilities.

18.4 Business Associate shall ensure that all Protected Health Information created, maintained, or received by Subcontractors is returned or, if agreed to by Covered entity, destroyed as provided for in Section 18.2.

19. AUDIT, INSPECTION, AND EXAMINATION

19.1 Covered Entity reserves the right to conduct a reasonable inspection of the facilities, systems, information systems, books, records, agreements, and policies and procedures relating to the Use or Disclosure of Protected Health Information for the purpose determining whether Business Associate is in compliance with the terms of this Business Associate Agreement and any non-compliance may be a basis for termination of this Business Associate Agreement and the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, as provided for in section 17.

19.2 Covered Entity and Business Associate shall mutually agree in advance upon the scope, timing, and location of any such inspection.

19.3 At Business Associate's request, and to the extent permitted by law, Covered Entity shall execute a nondisclosure agreement, upon terms and conditions mutually agreed to by the parties.

19.4 That Covered Entity inspects, fails to inspect, or has the right to inspect as provided for in Section 19.1 does not relieve Business Associate of its responsibility to comply with this Business Associate Agreement and/or the HIPAA Rules or impose on Covered Entity any responsibility for Business Associate's compliance with any applicable HIPAA Rules.

19.5 Covered Entity's failure to detect, its detection but failure to notify Business Associate, or its detection but failure to require remediation by Business Associate of an unsatisfactory practice by Business Associate, shall not constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Business Associate Agreement or the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

19.6 Section 19.1 is not intended by the parties to limit in any way the scope of Business Associate's obligations related to Inspection and/or Audit and/or similar review in the

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applicable underlying Agreement, Contract, Participation Agreement, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

20. MISCELLANEOUS PROVISIONS

20.1 Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with the terms and conditions of this Business Associate Agreement will be adequate or satisfactory to meet the business needs or legal obligations of Business Associate.

20.2 HIPAA Requirements. The Parties agree that the provisions under HIPAA Rules that are required by law to be incorporated into this Amendment are hereby incorporated into this Agreement.

20.3 No Third Party Beneficiaries. Nothing in this Business Associate Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

20.4 Construction. In the event that a provision of this Business Associate Agreement is contrary to a provision of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order, or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate, the provision of this Business Associate Agreement shall control. Otherwise, this Business Associate Agreement shall be construed under, and in accordance with, the terms of the applicable underlying Agreement, Contract, Master Agreement, Work Order, Purchase Order or other services arrangement, with or without payment, that gives rise to Contractor's status as a Business Associate.

20.5 Regulatory References. A reference in this Business Associate Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

20.6 Interpretation. Any ambiguity in this Business Associate Agreement shall be resolved in favor of a meaning that permits the parties to comply with the HIPAA Rules.

20.7 Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for Covered Entity or Business Associate to comply with the requirements of the HIPAA Rules and any other privacy laws governing Protected Health Information.