



County of San Bernardino

F A S

STANDARD CONTRACT

FOR COUNTY USE ONLY

<input checked="" type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Cancel	FAS Vendor Code	SC	Dept.	A	Contract Number
ePro Vendor Number					ePro Contract Number
County Department Behavioral Health			Dept. MLH	Orgn. MLH	Contractor's License No.
County Department Contract Representative Dennis Terrones			Telephone (909) 382-3032		Total Contract Amount \$ 2,500,000 Total Aggregate Maximum Obligation
Contract Type <input type="checkbox"/> Revenue <input type="checkbox"/> Encumbered <input checked="" type="checkbox"/> Unencumbered <input type="checkbox"/> Other:					
If not encumbered or revenue contract type, provide reason:					
Commodity Code					
Contract Start Date September 11, 2012		Contract End Date June 30, 2013		Original Amount \$	Amendment Amount
Fund AAA	Dept. MLH	Organization MLH	Appr. 200	Obj/Rev Source 2400	GRC/PROJ/JOB No. INDHSP Amount \$
Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No. Amount \$
Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No. Amount \$
Project Name Aggregate Maximum Obligation FFS Acute Psychiatric Inpatient Services Contract			Estimated Payment Total by Fiscal Year FY Amount I/D FY Amount I/D FY 12/13 \$2,500,000 _____ _____		

THIS CONTRACT is entered into in the State of California by and between the County of San Bernardino, hereinafter called the County, and

Name

Aurora Charter Oak Hospital

Address

1161 East Covina Boulevard

Covina, CA 91724

Telephone

(626) 966-1632

Federal ID No. or Social Security No.

hereinafter called Contractor

IT IS HEREBY AGREED AS FOLLOWS:

(Use space below and additional bond sheets. Set forth service to be rendered, amount to be paid, manner of payment, time for performance or completion, determination of satisfactory performance and cause for termination, other terms and conditions, and attach plans, specifications, and addenda, if any.)

WITNESSETH

**WHEREAS**, County has submitted the San Bernardino County Mental Health Plan (MHP) to the State of California to participate in Medi-Cal Mental Health Managed Care to provide a comprehensive and balanced range of mental health services; and

**WHEREAS**, County has determined that there is a need for psychiatric inpatient hospital services for residents who, due to mental illness, are a danger to self, others or gravely disabled; and

**WHEREAS**, Contractor hereby recognizes that this Contract is formed under the authority of the Welfare and Institutions (W & I) Code and the regulations adopted pursuant thereto, which authorize the County to contract for provision of psychiatric inpatient hospital services to beneficiaries eligible for such services under the Medi-Cal program in accordance with the rates, terms and conditions negotiated by the County:

**NOW, THEREFORE**, the parties hereto do mutually agree to terms and conditions as follows:

Auditor/Controller-Recorder Use Only

<input type="checkbox"/> Contract Database	<input type="checkbox"/> FAS
Input Date	Keyed By

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## **REFERENCED CONTRACT PROVISIONS**

**Term:** September 11, 2012 through June 30, 2013, inclusive.

**Aggregate Maximum Obligation:**

TOTAL AGGREGATE MAXIMUM OBLIGATION: \$2,500,000

**Basis for Reimbursement:**

Fee For Service

**Payment Method:**

Fee For Service

**Payment/Reimbursement Rate:**

Medi-Cal and Indigent Adult Acute Psychiatric Inpatient Day \$600 per day

Medi-Cal and Indigent Adolescent/Child Psychiatric Inpatient Day \$700 per day

Medi-Cal Administrative Day Rate established by state DMH

Indigent Administrative Day Will not be reimbursed

**Notices to County and Contractor:**

COUNTY: County of San Bernardino  
Department of Behavioral Health  
Contracts Unit  
268 West Hospitality Lane, Suite 400  
San Bernardino, CA 92415-0026

CONTRACTOR: Aurora Charter Oak Hospital  
1161 East Covina Boulevard  
Covina, CA 91724

## I. Definition of Terminology

- A. Wherever in this document and in any attachments hereto, the terms "Contract" and/or "Agreement" are used to describe the conditions and covenants incumbent upon the parties hereto, these terms are interchangeable.
- B. Definition of May, Shall and Should. Whenever in this document the words "may", "shall" and "should" are used, the following definitions shall apply: "may" is permissive; "shall" is mandatory; and "should" means desirable.
- C. The term "County's billing and transactional database system" refers to the centralized data entry system used by the Department of Behavioral Health (DBH) for patient and billing information.
- D. The term "Director," unless otherwise stated, refers to the Director of Behavioral Health for the County of San Bernardino.
- E. The following definitions pertaining to Medi-Cal Psychiatric Inpatient Hospital Services are applicable hereunder:
  - 1. Administrative Day Services is defined in Title 9, California Code of Regulations (CCR) Section 1701 as " Services authorized by a Mental Health Plan's Point of Authorization or a Short-Doyle/Medi-Cal provider's Utilization Review Committee that is acting as a Point of Authorization, for a beneficiary residing in a psychiatric inpatient hospital when, due to a lack of residential placement options at appropriate, non-acute treatment facilities as identified by the Mental Health Plan, the beneficiary's stay at the psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services." During the hospital stay, the beneficiary must also have met the medical necessity criteria for acute psychiatric inpatient hospital services.

The San Bernardino County Mental Health Plan has identified the following as Medi-Cal eligible non-acute treatment facilities that meet the Administrative Day Service criteria:

- a. State Hospital;
- b. Skilled Nursing facilities with a psychiatric component;
- c. Institute for Mental Disease;
- d. Licensed augmented board and care. These are designated board and care facilities that have a contract with DBH to provide specialized enhanced services to targeted populations. Non-augmented licensed board and care facilities do not qualify for administrative day reimbursement;

- e. Group Home with an RCL rating of 10 or above (the case manager from the county placing agency should be involved to determine that the level of placement is appropriate).
- 2. Ancillary services: Use of hospital facilities; laboratory, medical and social services furnished by the hospital; drugs such as take home drugs, biologicals, supplies, appliances and equipment; nursing, pharmacy and dietary services; and administrative services required to provide such services.
- 3. Beneficiary: Any person certified as eligible for services under the Medi-Cal Program according to Title 22, CCR.
- 4. Border community: Out of State community with providers that frequently serve Medi-Cal beneficiaries from California - i.e., Reno, Klamath Falls, Medford, Yuma.
- 5. Complaint Resolution Process: An informal process at the county or provider level whereby beneficiary complaints and concerns regarding mental health services are addressed by easily understood processes with the intent of resolving as many disputes as possible at this level.
- 6. Consolidation: Transfer of Fee-for-Service/Medi-Cal psychiatric inpatient hospital services to create a single entity responsible for funding and authorization for medically necessary psychiatric inpatient hospital services for Medi-Cal beneficiaries.
- 7. Emergency psychiatric condition: A condition that exists when a Medi-Cal beneficiary requires voluntary or involuntary hospitalization because he/she meets the criteria for medical necessity for psychiatric inpatient hospital services and presents, as a result of a mental disorder; as:
  - a. A danger to self, or
  - b. A danger to others, or
  - c. Immediately unable to provide for or utilize food, shelter or clothing.
- 8. Fee-for-Service/Medi-Cal: California's Medicaid program that provides reimbursement for a broad array of health and limited mental health services to eligible individuals.
- 9. Fiscal intermediary: That person who or entity which has contracted, as specified in W & I Code, to perform fiscal intermediary services for Fee-for-Service/Medi-Cal providers.
- 10. Grievance process: A written or verbal beneficiary statement that initiates a dispute resolution process at the county level, which requires a written county response.

11. Licensed mental health professionals: Includes physicians, psychologists, licensed clinical social workers, marriage and family therapists, registered nurses, licensed vocational nurses, and psychiatric technicians.
12. Medical necessity criteria: The principal criteria by which a mental health plan will determine authorization for payment for acute psychiatric inpatient hospital services.
13. Mental health plan: An entity, which enters into an agreement with the State to provide Medi-Cal beneficiaries from a specific county with psychiatric inpatient hospital services. The plan may be a county, counties acting jointly, or other governmental or nongovernmental entity.
14. Non-contract facility: A provider of psychiatric inpatient hospital services with which a mental health plan has not contracted.
15. Prior authorization: Requirement for written approval for payment before services are rendered.
16. Psychiatric inpatient hospital services: Services provided either in an acute care hospital or a freestanding psychiatric hospital for the care and treatment of an acute episode of mental illness. Services provided in a freestanding hospital may only be reimbursed by Medi-Cal under the following conditions:
  - a. A person is 65 years of age or older, or
  - b. The person is under 21 years of age, or
  - c. The person was receiving such services prior to his/her twenty-first birthday and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier.
17. Quality Management Plan: A document that establishes procedures for the objective and systematic monitoring and evaluation of the quality and appropriateness of services to Medi-Cal beneficiaries. It also identifies ways to solve system problems and improve services.
18. Traditional hospital provider: A provider that, according to the latest historical payment data, provides services to residents of a county that account for five percent or \$20,000 (whichever is more) of the total fiscal year Fee-for-Service/Medi-Cal psychiatric inpatient hospital service payments made for beneficiaries of the county.

## II. Contract Supervision

The Director or designee shall be the County employee authorized to represent the interests of the County in carrying out the terms and conditions of this Contract. The Contractor shall provide, in writing, the names of the persons who are authorized to represent the Contractor in this Contract.

### III. Performance

- A. Under this Agreement, the Contractor shall provide those services, which are dictated by attached Addenda, Schedules and/or Attachments. The Contractor agrees to be knowledgeable in and apply all pertinent Federal and State laws and regulations as referenced in the body of this Agreement. In the event information in the Addendum, Schedules and/or Attachments conflicts with the basic Agreement, then information in the Addendum, Schedules and/or Attachments shall take precedence to the extent permitted by law.
- B. Contractor agrees to render psychiatric inpatient hospital services to eligible beneficiaries in need of such services and assumes full responsibility for provision of all psychiatric inpatient hospital services in accordance with regulations adopted pursuant to the W&I Code and as provided in this Contract. Contractor agrees to accept, as payment in full for any and all psychiatric inpatient hospital services, payments made pursuant to Article V Payment of this Contract. The County agrees to pay the Contractor for such services rendered in accordance with the terms, and under the express conditions of, this Contract.
- C. Contractor assumes full responsibility for provision of all psychiatric inpatient hospital services in accordance with the W&I Code and regulations adopted pursuant thereto W&I Code and as provided in this Contract. Contractor agrees to accept, as payment in full for any and all psychiatric inpatient hospital services, payments made pursuant to Article V Payment of this Contract. The County agrees to pay the Contractor for such services rendered in accordance with the terms, and under the express conditions of, this Contract.
- D. Contractor shall, at its own expense, provide and maintain facilities and professional, allied and supportive paramedical personnel to provide all necessary and appropriate psychiatric inpatient hospital services.
- E. Contractor shall, at its own expense, provide and maintain the organizational and administrative capabilities to carry out its duties and responsibilities under this Contract and all applicable statutes and regulations pertaining to Medi-Cal providers.
- F. State Performance Outcome Requirements  
Contractor shall comply with all State regulations regarding State Performance Outcomes measurement requirements and participate in the outcomes measurement process, as required by the State.
- G. Right to Monitor and Audit Performance and Records
  - 1. Right to Monitor  
County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all applicable records, books, papers, documents, corporate minutes, financial records, and other items related to this agreement as requested, and shall have absolute right to monitor the

performance of Contractor in the delivery of services provided under this Contract. Full cooperation shall be given by Contractor in any related auditing or monitoring conducted.

Contractor shall cooperate with County in the implementation, monitoring and evaluation of this agreement and comply with any and all reporting requirements established by County.

2. Availability of Records

Contractor shall maintain all records and management books pertaining to local service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program.

Records, should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the appropriate Office of Management and Budget (OMB) Circulars which state the administrative requirements, cost principles and other standards for accountancy and shall be retained for at least seven (7) years from the date of final payment or final settlement, or until audit findings are resolved, whichever is longer.

All records shall be complete and current and comply with all Contract requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of a Contract.

The Contractor shall maintain client and community service records in compliance with all regulations set forth by the State Department of Mental Health (DMH) and provide access to clinical records by DBH staff.

The Contractor shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.

The Contractor shall agree to maintain and retain all appropriate service and financial records for a period of at least seven (7) years, or until audit findings are resolved, whichever is later.

3. Assistance by Contractor

Contractor shall provide all reasonable facilities and assistance for the safety and convenience of County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work of the Contractor.

- H. Notwithstanding any other provision of this Agreement, the County may withhold all payments due to the Contractor, if the Contractor has been given at least thirty (30) days notice of any deficiency(ies) and has failed to correct such deficiency(ies). Such

deficiency(ies) may include, but are not limited to: failure to provide services described in this Agreement; Federal, State, and County audit exceptions resulting from noncompliance, and significant performance problems as determined by the Director or his/her designee from monitoring visits.

I. Cultural Competency

The State Department of Mental Health mandates counties to develop and implement a Cultural Competency Plan. This Plan applies to all DBH Services. Policies and procedures and all services must be culturally and linguistically appropriate. Contract agencies will be included in the implementation process of the most recent state approved cultural competency plan for the County of San Bernardino and shall adhere to all cultural competency standards and requirements.

1. Cultural and Linguistic Competency. Cultural competence is defined as a set of congruent practice behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enable that system, agency, or those professional and consumer providers to work effectively in cross-cultural situations.
  - a. The Contractor shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health and substance abuse services.
  - b. The DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing medically necessary specialty behavioral health and substance abuse services in a culturally competent manner is fundamental in any effort to ensure success of high quality and cost-effective behavioral health and substance abuse services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost-effective.
  - c. To assist the Contractor's efforts towards cultural and linguistic competency, the DBH shall provide the following:
    - i. Technical assistance to the Contractor regarding cultural competency implementation.
    - ii. Demographic information to the Contractor on service area for services planning.

- iii. Cultural competency training for Department and Contractor personnel. Contractor staff is encouraged to attend at least one cultural competency training per year.
- iv. Interpreter training for Department and Contractor personnel.
- v. Technical assistance for the Contractor in translating behavioral health and substance abuse services information to the DBH's threshold language (Spanish).

J. Site Inspection

Contractor shall permit authorized County, State, and/or Federal Agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. The Contractor shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

K. Collections Costs

Should the Contractor owe monies to the County for reasons including, but not limited to, Quality Management review, cost-settlement, and/or fiscal audit, and the Contractor has failed to pay the balance in full or remit mutually agreed upon payment, the County may refer the debt for collection. Collection costs incurred by the County shall be recouped from the Contractor. Collection costs charged to the contractor are not a reimbursable expenditure under the contract.

#### IV. Funding

A. Maximum Obligation

The Aggregate Maximum Obligation of San Bernardino County for services provided in accordance with all agreements for Acute Inpatient Services meeting Medical Necessity Criteria for Indigent Patients during the term of this Agreement are as specified on the Referenced Contract Provisions of this Agreement. This specific Agreement with Contractor is only one of several agreements to which this Aggregate Maximum Obligation applies. It therefore is understood by the parties that reimbursement to Contractor will be only a fraction of this Aggregate Maximum with the appropriate authorization.

B. Contingent Funding

- 1. Any obligation of COUNTY under this Agreement is contingent upon the following:
  - a. The continued availability of federal, state and county funds for reimbursement of COUNTY's expenditures, and

- b. Inclusion of sufficient funding for the services hereunder in the applicable budget approved by the Board of Supervisors.
2. In the event such funding is subsequently reduced or terminated, County or Contractor may terminate or renegotiate this Agreement upon thirty (30) calendar days written notice given CONTRACTOR. If COUNTY elects to renegotiate this Agreement due to reduced or terminated funding, CONTRACTOR shall not be obligated to accept the renegotiated terms.

#### V. Payment

- A. County shall pay Contractor, at the rates specified on the Referenced Contract Provisions of this agreement; provided, however, the total of all payments to Contractor and all other contract providers of Adult Indigent Mental Health Inpatient Services shall not exceed County's Aggregate Maximum Obligation.
  1. Contractor shall submit Treatment Authorization Requests (TARs) to County for all Medi-Cal eligible patients and UB-92s for all Medically Indigent patients in accordance with the procedures that are further described in Attachment II
  2. County will review TARs and UB92s to insure compliance. Approved TARs will be forwarded to the state claims intermediary [Electronic Data Systems (EDS)] for reimbursement. Approved UB92s will be forwarded to DBH Fiscal Services for reimbursement
- B. Indigent Care Reimbursement: The Department of Behavioral Health will reimburse contract hospitals for treatment of Medically Indigent Patients who meet all of the medical necessity criteria specified in Attachment II, DBH Maximum Obligation and Reimbursement Requirements. Indigent Care Reimbursement will be contingent upon San Bernardino County residency and substantiation of ineligibility for other coverage. Administrative days will not be reimbursed for indigent patients. The rate structure under Article V Payment Paragraph A. of this Contract is intended by both the County and the Contractor to be inclusive of all services of this Contract.
- C. The rate structure under Article V Payment Paragraph A. of this Contract shall not include physician services nor non-hospital based ancillary services rendered to beneficiaries covered under this Contract, or transportation services required in providing Psychiatric Inpatient Hospital Services. When physician and non-hospital based ancillary services or transportation services are Medi-Cal eligible services, they shall be billed separately from the per diem rate for Psychiatric Inpatient Hospital Services
- D. As an express condition precedent to the County's payment obligation under Article V Payment Paragraph A. of this Contract, the Contractor shall determine that psychiatric inpatient hospital services rendered hereunder are not covered, in whole or in part, under any other state or federal medical care program or under any other contractual or legal entitlement, including, but not limited to, a private group

indemnification or insurance program or worker's compensation. To the extent that such coverage is available, the County's payment obligation pursuant to Article V Payment Paragraph A. shall be reduced.

- E. Following notification from Administrator that any client served under this contract has become eligible for Medi-Cal, Contractor agrees to submit retroactive Medi-Cal Treatment Authorization Requests (TARs) to Administrator for review. Further, Contractor agrees to submit hospital claims to EDS and upon receipt of payment, will make best efforts to refund the County within sixty (60) days for the total amount previously paid for bed day stay less payment made for professional services during the Medi-cal eligibility period.
- F. The Contractor shall bear total risk for the cost of all psychiatric inpatient hospital services rendered to each beneficiary covered by this Contract. As used in this Article, "risk" means that the Contractor agrees to accept, as payment in full for any and all psychiatric inpatient hospital services (exclusive of physician services), payments made pursuant to Article V Payment of this Contract. Such acceptance shall be made irrespective of whether the cost of such services and related administrative expenses shall have exceeded the payment obligation of the County under the conditions set forth in this Contract. The term "risk" also includes, but is not limited to, the cost for all psychiatric inpatient hospital services for illness or injury which results from or is contributed to by catastrophe or disaster which occurs subsequent to the effective date of this Contract, including but not limited to acts of God, war or the public enemy.
- G. Contractor shall accept all payments from County via electronic funds transfer (EFT) directly deposited into the Contractor's designated checking or other bank account. Contractor shall promptly comply with directions and accurately complete forms provided by County required to process EFT payments.
- H. Contractor shall be in compliance with the Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

#### VI. Electronic Signatures

- A. The state Department of Mental Health (DMH) and Alcohol and Drug Programs (ADP) have each respectively established the requirements for electronic signatures in electronic health record systems. DBH has sole discretion to authorize contractors to use e-signatures as applicable. If a contractor desires to use e-signatures in the performance of this contract the contractor shall:
  - 1. Submit the request in writing to DBH Office of Compliance at the following address:

DBH Office of Compliance  
268 W. Hospitality Ln., Ste. 400  
San Bernardino, CA. 92415

2. Fulfill all requisite pre-conditions and meet all the latest requirements of DBH, DMH and/or ADP.
  3. Obtain prior written approval from the Director of DBH or his designee.
- B. DBH reserves the right to terminate e-signature authorization at will.

VII. Final Settlement: Audits

- A. Contractor agrees to maintain and retain all appropriate service and financial records for a period of at least seven years, or until audit findings are resolved, whichever is later. This is not to be construed to relieve Contractor of the obligations concerning retention of medical records as set forth in Article XIX Medical Records/Protected Health Information, Paragraphs A and B.
- B. Contractor agrees to furnish duly authorized representatives from County and State access to patient/client records and to disclose to State and County representatives all financial records necessary to review or audit Contract services and to evaluate the cost, quality, appropriateness and timeliness of services. Said County or State representative shall provide a signed copy of a confidentiality statement similar to that provided for in Section 5328(e) of the Welfare and Institutions Code, when requesting access to any patient records. Contractor will retain said statement for its records.
- C. If the appropriate agency of the State of California, or the County, determines that all, or any part of, the payments made by County to Contractor pursuant hereto are not reimbursable in accordance with this Agreement, said payments will be repaid by Contractor to County. In the event such payment is not made on demand, County may withhold monthly payment on Contractor's claims until such disallowances are paid by Contractor and/or County may terminate and/or indefinitely suspend this Agreement immediately upon serving written notice to the Contractor.
- D. The eligibility determination and the fees charged to, and collected from, patients whose treatment is provided for hereunder may be audited periodically by County and the DMH.
- E. If the audit reveals that money is payable from one party to the other, that is, reimbursement by Contractor to County, or payment of sums due from County to Contractor, said funds shall be due and payable from one party to the other within sixty (60) calendar days of receipt of the audit results. If reimbursement is due from Contractor to County, and such reimbursement is not received within said sixty (60) calendar days, County may, in addition to any other remedies, reduce any amount owed Contractor by an amount not to exceed the reimbursement due County.

- F. Contractor agrees to cooperate with County in the implementation, monitoring and evaluation of inpatient mental health services and to comply with any and all reporting requirements established by County, the State of California and any and all Federal agencies providing monies for the services described herein.
- G. The Contractor shall comply with the applicable provisions of 42 C.F.R. sections 455.100 through 455.106.
- H. If there is a conflict between a State of California audit of this Agreement and a County audit of this Agreement, the State audit shall take precedence.

#### VIII. Single Audit Requirement

- A. Pursuant to OMB Circular A-133, Contractors expending the threshold amount or more in Federal funds in a year through a Contract with County must have a single or program-specific audit performed which shall comply with the following requirements:
  - 1. The audit shall be performed by a licensed Certified Public Accountant (CPA) in accordance with OMB Circular A-133 (latest revision), Audits of States, Local Governments, and Non-Profit Organizations.
  - 2. The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, latest revision, issued by the Comptroller General of the United States.
  - 3. A copy of the audit performed in accordance with the provisions of OMB Circular A-133 shall be submitted to the County within thirty (30) days of completion, but no later than nine (9) months following the end of the Contractor's fiscal year.
  - 4. The cost of the audit made in accordance with the provisions of OMB Circular A-133 can be charged to applicable Federal funds. Where apportionment of the audit is necessary, such apportionment shall be made in accordance with generally accepted accounting principles, but shall not exceed the proportionate amount that the Federal funds represent of the Contractor's total revenue.
  - 5. The work papers and the audit reports shall be retained for a minimum of seven (7) years from the date of the audit reports, and longer if the independent auditor is notified in writing by the County to extend the retention period.
  - 6. Audit work papers shall be made available upon request to the County, and copies shall be made as reasonable and necessary.
  - 7. The Contractor is responsible for follow-up and corrective action on all audit findings in the single or program-specific audit report, as directed by the County in coordination with the State.

- B. The Contractor shall comply with the applicable provisions of 42 C.F.R. sections 455.100 through 455.106.

IX. Contract Performance Notification

In the event of a problem or potential problem that will impact the quality or quantity of work or the level of performance under this Contract, notification will be made within one working day, in writing and by telephone to the County.

X. Duration and Termination

- A. The term of this agreement shall be as specified on the Referenced Contract Provisions of this Agreement.
- B. This agreement may be terminated immediately by the Director at any time if:
1. The appropriate office of the State of California indicates that this agreement is not subject to reimbursement under law; or
  2. There are insufficient funds available to County; or
  3. The State or Director determines that the Contractor is abusing or defrauding, or has abused or defrauded, the Medi-Cal program or its beneficiaries; or
  4. The Contractor is found not to be in compliance with any or all of the terms of the herein incorporated Articles of this agreement or any other material terms of the contract.
- C. Either the Contractor or Director may terminate this agreement at any time for any reason or no reason by serving 30 days' written notice upon the other party.
- D. This agreement may be terminated at any time by the mutual written concurrence of both the Contractor and the Director.
- E. If Contractor anticipates ceasing operation of its facility for any reason, County is to be notified by Contractor in writing immediately upon such anticipation, or no less than 24 hours prior to cessation. Arrangements are to be made by Contractor with County approval for preservation of the program activity and financial records.

XI. Accountability: Revenue

A. Client Fees

Contractor shall charge, unless waived by Administrator, a fee to patients to whom services, other than Medi-Cal Services, are provided pursuant to this Agreement, their estates and responsible relatives, according to their ability to pay as determined by the State Department of Mental Health's "Uniform Method of Determining Ability to Pay" (UMDAP) procedure, and in accordance with Title 9 of the California Code of Regulations, or Contractor's standard policy. No client shall be denied service because of inability to pay.

B. Third-Party Revenue

Contractor shall make every reasonable effort to obtain all available third-party reimbursement for which persons served hereunder may be eligible. Charges to insurance carriers shall be on the basis of Contractor's usual and customary charges.

C. Procedures

Contractor shall maintain internal financial controls which adequately ensure proper billing and collection procedures. Contractor's procedures shall specifically provide for the identification of delinquent accounts and methods for pursuing such accounts.

XII. Personnel

A. Contractor shall operate continuously throughout the term of this agreement with at least the minimum number of staff as required by Title 9 and 22 of the California Code of Regulations for the mode(s) of service described in this agreement. Contractor shall also satisfy any other staffing requirements necessary to participate in the Short-Doyle/Medi-Cal program, if so funded.

B. Contractor shall make available to County, on request, a list of the persons who shall provide services under this Agreement. Said list shall include name, title, professional degree and job description.

C. Contractor agrees to provide or has already provided information on former County of San Bernardino administrative officials (as defined below) who are employed by or represent Contractor. The information provided includes a list of former County administrative officials who terminated County employment within the last five years and who are now officers, principals, partners, associates or members of the business. The information also includes the employment with or representation of Contractor. For purposes of this provision, "County administrative official" is defined as a member of the Board of Supervisors or such officer's staff, Chief Executive Officer or member of such officer's staff, County department or group head, assistant department or group head, or any employee in the Exempt Group, Management Unit or Safety Management Unit. If during the course of the administration of this agreement, the County determines that the Contractor has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to the County, this contract may be immediately terminated. If this contract is terminated according to this provision, the County is entitled to pursue any available legal remedies.

D. Contractors shall obtain records from the Department of Justice of all convictions of persons offered employment or volunteers as specified in Penal Code Section 11105.3.

E. **IRAN CONTRACTING ACT OF 2010**

In accordance with Public Contract Code section 2204(a), the Contractor certifies that at the time the Contract is signed, the Contractor signing the Contract is not identified on a list created pursuant to subdivision (b) of Public Contract Code section 2203 (<http://www.dgs.ca.gov/pd/Resources/PDLegislation.aspx>) as a person (as defined in Public Contract Code section 2202(e)) engaging in investment activities in Iran described in subdivision (a) of Public Contract Code section 2202.5, or as a person described in subdivision (b) of Public Contract Code section 2202.5, as applicable.

Contractors are cautioned that making a false certification may subject the Contractor to civil penalties, termination of existing contract, and ineligibility to bid on a contract for a period of three (3) years in accordance with Public Contract Code section 2205.

### XIII. Licensing and Certification

- A. Contractor hereby represents and warrants that it is currently, and for the duration of this Contract shall remain, licensed as a general acute care hospital or acute psychiatric hospital in accordance with Section 1250 et seq. of the Health and Safety Code and the licensing regulations contained in Title 22 and Title 17 of the California Code of Regulations.
- B. Contractor hereby represents and warrants that it is currently, and for the duration of this Contract shall remain, certified under Title XVIII of the Federal Social Security Act.
- C. Contractor shall operate continuously throughout the term of this agreement with all licenses, certifications and/or permits as are necessary to the performance hereunder. Failure to maintain a required license or permit may result in immediate termination of this contract.
- D. Contractor shall ensure all service providers apply for, obtain and maintain the appropriate certification, licensure, registration or waiver prior to rendering services. Service providers may not render services without a valid certification, licensure, registration or waiver.
- E. Contractor shall comply with applicable provisions of the:
  - 1. Business and Professions Code, Division 2
  - 2. California Code of Regulations, Title 16
- F. Contractor shall comply with the United States Department of Health and Human Services, Office of Inspector General (OIG) requirements related to eligibility for participation in Federal and State health care programs.
  - 1. Ineligible Persons may include both entities and individuals and are defined as any individual or entity who:

- a. Is currently excluded, suspended, debarred or otherwise ineligible to participate in the Federal and State health care programs; or
  - b. Has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal and State health care programs after a period of exclusion, suspension, debarment, or ineligibility.
2. Contractor shall review the organization and all its employees, subcontractors, agents, physicians and persons having five percent (5%) or more of direct or indirect ownership or control interest of the Contractor for eligibility against the United States General Service Administration's Excluded Parties List System (EPLS) and the OIG's List of Excluded Individuals/Entities (LEIE) respectively to ensure that Ineligible Persons are not employed or retained to provide services related to this Contract.
  - a. The EPLS can be accessed at <http://www.epls.gov/>.
  - b. The LEIE can be accessed at <http://oig.hhs.gov/fraud/exclusions.asp>.
3. If the Contractor receives Medi-Cal reimbursement, Contractor shall review the organization and all its employees, subcontractors, agents and physicians for eligibility against the California Department of Health Care Services Suspended and Ineligible Provider List to ensure that Ineligible Persons are not employed or retained to provide services related to this Contract.
  - a. The Suspended and Ineligible Provider List can be accessed at <http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/part1201202.asp>.
4. Contractor shall certify that no staff member, officer, director, partner, or principal, or sub-contractor is "excluded" or "suspended" from any federal health care program, federally funded contract, state health care program or state funded contract. This certification shall be documented by completing the Attestation Regarding Ineligible / Excluded Persons (Attachment VIII) at time of the initial contract execution and annually thereafter. The Attestation Regarding Ineligible / Excluded Persons shall be submitted to the following program and address:

DBH Office of Compliance  
268 W. Hospitality Lane, Suite 400  
San Bernardino, CA 92415
5. Contractor acknowledges that Ineligible Persons are precluded from providing Federal and State funded health care services by contract with County in the event that they are currently sanctioned or excluded by a Federal or State law enforcement regulatory or licensing agency.

#### XIV. Administrative Procedures

- A. Contractor agrees to adhere to all applicable provisions contained in the San Bernardino County Local Managed Mental Health Care Plan and the Medi-Cal Psychiatric Inpatient Hospital Services Emergency Regulations which are included as a part of this Contract by this reference.
- B. Contractor agrees to adhere to all applicable provisions of:
  - 1. State DMH Information Notices, and;
  - 2. DBH Information Notices, and;
  - 3. County Department of Behavioral Health (DBH) Standard Practice Manual (SPM). Both the State DMH Information Notices and DBH SPM are included as a part of this contract by reference.
- C. If a dispute arises between the parties to this agreement concerning the interpretation of any State DMH Information Notice or DBH SPM, the parties agree to meet with the Director to attempt to resolve the dispute.
- D. State DMH Information Notices shall take precedence in the event of conflict with the terms and conditions of this agreement.

#### XV. Laws and Regulations

- A. Contractor agrees to comply with all relevant Federal and State laws and regulations inclusive of future revisions and comply with all applicable provisions of:
  - 1. Mental Health Plan (MHP) contract with the State Department of Mental Health
  - 2. California Code of Regulations Title 9
  - 3. California Code of Regulations Title 22
  - 4. Welfare and Institutions Code
  - 5. Titles 42 and 45 (Part 74) of the Code of Federal Regulations and all other applicable federal laws and regulations except for those provisions waived by the Secretary of Health and Human Services.
  - 6. Policies as identified in State policy letters.
- B. Health and Safety

Contractor shall comply with all applicable State and local health and safety requirements and clearances, including fire clearances, for each site where program services are provided under the terms of the Contract.
- C. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, regulations have been promulgated governing the privacy and security of

individually identifiable health information (IIHI) otherwise defined as Protected Health Information (PHI) or electronic Protected Health Information (ePHI). The HIPAA Privacy and Security Regulations specify requirements with respect to contracts between an entity covered under the HIPAA Privacy and Security Regulations and its Business Associates. A Business Associate is defined as a party that performs certain services on behalf of, or provides certain services for, a Covered Entity and, in conjunction therewith, gains access to IIHI, or PHI or ePHI. Therefore, in accordance with the HIPAA Privacy and Security Regulations, Contractor shall comply with the terms and conditions as set forth in the attached Business Associate Agreement, hereby incorporated by this reference as Attachment VII.

D. Program Integrity Requirements:

1. General Requirement. Pursuant to Title 42 C.F.R. Section 438.608, Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan that are designed to guard against fraud and abuse.
2. Compliance Program. County has established an Office of Compliance for purposes of ensuring adherence to all standards, rules and regulations related to the provision of services and expenditure of funds in Federal and State health care programs. If Contractor has established its own Compliance Program, Contractor shall provide documentation to County to evaluate whether the Program is consistent with the elements of a Compliance Program as recommended by the United States Department of Health and Human Services Office of Inspector General. Contractor's program must include the designation of a compliance officer and compliance committee that are accountable to senior management and/or Board of Directors in addition to the specific requirements listed below.

Should the Contractor develop its own Compliance Plan, it shall submit the plan prior to implementation to the following DBH Program for review and approval:

DBH Office of Compliance  
268 W. Hospitality Lane, Suite 400  
San Bernardino, CA 92415

3. Specific Requirements. The administrative and management arrangements or procedures must include the following:
  - a. **Policies and Procedures:** Written policies and procedures that articulate the Contractor's commitment to comply with all applicable Federal and State standards. Contractor shall adhere to applicable DBH Policies and Procedures relating to the Compliance Program or develop its own Compliance related policies and procedures.

- i. **Contractor** shall maintain documentation, verification or acknowledgement that the Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors are aware of these Policies and Procedures and the Compliance Program.
- b. **Code of Conduct:** Contractor shall either adopt the DBH Code of Conduct or develop its own Code of Conduct.
  - i. If Contractor elects to develop and adopt its own Code of Conduct, such document shall be reviewed and approved, in writing, by the County.
  - ii. Contractor shall distribute to all Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors a copy of the Code of Conduct. Contractor shall document that such persons have received, read, understand and will abide by said Code.
- c. **Excluded/Ineligible Persons:** Contractor shall comply with Section XI, Personnel of this contract related to excluded and ineligible status in Federal and State health care programs.
- d. **Internal Monitoring and Auditing:** Contractor shall be responsible for conducting internal monitoring and auditing of its agency. Internal monitoring and auditing include, but are not limited to billing and coding practices, licensure/credential/registration/waiver verification and adherence to County, State and Federal regulations.
  - i. Contractor shall take reasonable precaution to ensure that the coding of health care claims and billing for same are prepared and submitted in an accurate and timely manner and are consistent with Federal, State and County laws and regulations as well as DBH's policies and/or agreements with third party payers. This includes compliance with Federal and State health care program regulations and procedures or instructions otherwise communicated by regulatory agencies including the Centers for Medicare and Medicaid Services or its agents.
  - ii. Contractor shall not submit false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.
  - iii. Contractor shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, Contractor shall use only correct billing codes that accurately describe the services provided.

- iv. Contractor shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified by the County, Contractor, outside auditors, etc.
- v. Contractor shall ensure all service providers maintain current licensure/credential/registration/waiver status as required by the respective licensing Board. Contractors shall ensure the Staff Master is updated with the current employment and license/credential/registration/waiver status in order to bill for services.
- e. **Response to Detected Offenses:** Contractor shall respond to and correct detected offenses relating to this contract promptly. Contractor shall be responsible for developing corrective action initiatives for offenses.
- f. **Compliance Training:** Contractor is responsible for conducting Compliance Training, if it has a Compliance Program that is approved by DBH. Contractor is encouraged to attend DBH Compliance trainings, as offered and available.
- g. **Enforcement of Standards:** Contractor shall enforce compliance standards uniformly and through well-publicized disciplinary guidelines. If Contractor does not have a Compliance Program, the County requires the Contractor utilize DBH policies and procedures as guidelines when enforcing compliance standards
- h. **Communication:** Contractor shall establish and maintain effective lines of communication between the Compliance Officer for the Contractor and the employees. If a Contractor does not have an approved Compliance hotline, the County shall provide use of its DBH Compliance Hotline (800) 398-9736, for Contractor employees.
- i. In accordance with the Termination paragraph of this Agreement, County may terminate this Agreement upon thirty (30) days written notice if Contractor fails to perform any of the terms of this Compliance paragraph. At County's sole discretion, Contractor may be allowed up to thirty (30) days for corrective action.

#### XVI. Patients' Rights

Contractor shall adopt and post in a conspicuous place a written policy on patients' rights in accordance with Title 22 of the California Code of Regulations and with the W&I Code. Complaints by beneficiaries with regard to substandard conditions may be investigated by the County's Patients' Rights Advocate, other County departments or agencies, the State Department of Mental Health or by the Joint Commission on Accreditation of Healthcare Organizations, or such other agency, as required by law or regulation.

Contractor shall take all appropriate steps to fully protect patients' rights, as specified in Welfare and Institutions Code Sections 5325 et seq.

#### XVII. Confidentiality

Contractor agrees to comply with confidentiality requirements contained in Health Insurance Portability and Accountability Act (HIPAA) of 1996, commencing with subchapter C, and Welfare and Institutions Code, commencing with Section 5328.

#### XVIII. Admission Policies

Contractor shall admit and discharge patients in accordance with policies and procedures that are described in the applicable attached Addendum and Attachments.

- A. Contractor shall develop patient/client admission policies, which are in writing and available to the public.
- B. Contractor's admission policies shall adhere to policies that are compatible with Department of Behavioral Health service priorities, and Contractor shall admit patients according to procedures and time frames established by DBH.
- C. If Contractor is found not to be in compliance with the terms of this Article XVIII Admission Policies, this agreement may be subject to termination.

#### XIX. Medical Records/Protected Health Information

- A. Contractor agrees to maintain and retain medical records according to the following:
  - 1. The minimum maintenance requirement of medical records is:
    - a. The information contained in the medical record shall be confidential and shall be disclosed only to authorized persons in accordance to local, state and federal laws.
    - b. Documents contained in the medical record shall be written legibly in ink or typewritten, be capable of being photocopied and shall be kept for all patients accepted for care or admitted, if applicable.
    - c. If the medical record is electronic, the Contractor shall make the computerized records accessible for County's review.
  - 2. The minimum legal requirement for the retention of medical records is:
    - a. For adults and emancipated minors, seven (7) years following discharge (last date of service);
    - b. For unemancipated minors, at least one year after they have attained the age of 18, but in no event less than seven (7) years following discharge (last date of service).

- c. County shall be informed within three (3) business days, in writing, if client medical records are defaced or destroyed prior to the expiration of the required retention period.
- B. Contractor shall ensure that all patient/client records comply with any additional applicable State and Federal requirements.
- C. Contractor agrees to furnish duly authorized representatives from County and State access to patient/client records.
- D. The Protected Health Information under this Contract shall be and remain the property of the County. The Contractor agrees that it acquires no title or rights to the Protected Health Information, with the exception of inpatient facilities.
- E. In the event this contract is terminated, Contractor shall deliver or make available to DBH all data, reports, records and other such information and materials that may have been accumulated by Contractor under this Contract, whether completed, partially completed or in progress within seven (7) calendar days of said termination.
  - 1. If the Contractor shall cease operation of its business, the County shall store the medical records for all the Contractor's county funded patients.
  - 2. The Contractor shall maintain responsibility for the medical records of non-county funded patients.
  - 3. The Contractor shall be responsible for the boxing, indexing and delivery of any and all records that will be stored by the County medical records department.
  - 4. Should the Contractor fail to relinquish the medical records to the County, the County shall report the Contractor and its qualified professional personnel to the applicable licensing or certifying board(s).
  - 5. Contractor shall return all electronic Protected Health Information received from or created by its subcontractor, employees or agents on behalf of the Contractor to the County for the sole purpose of final destruction from Contractor's electronic devices, with the exception of inpatient facilities.

XX. Quality Assurance/Utilization Review

- A. Contractor agrees to be in compliance with Laws and Regulations as listed in Article XV Laws and Regulations of this contract.
- B. Contractor agrees to implement a Quality Improvement Program as part of program operations. This program will be responsible for monitoring Documentation, Quality Improvement and Quality Care issues. Contractor will submit to DBH Quality Management Division on an annual basis, any tools/documents used to evaluate Contractor's Documentation, Quality of Care and the Quality Improvement process.

- C. When Quality of Care documentation or issues are found to exist by DBH, Contractor shall submit a plan of correction to be approved by DBH Quality Management/Compliance Unit.
- D. Contractor agrees to be part of the County Quality Improvement planning process through the annual submission of Quality Improvement Outcomes in County identified areas.

#### XXI. Independent Contractor Status

Contractor understands and agrees that the services performed hereunder by its officers, agents, employees, or contracting persons or entities are performed in an independent capacity and not in the capacity of officers, agents or employees of the County.

All personnel, supplies, equipment, furniture, quarters, and operating expenses of any kind required for the performance of this contract shall be provided by Contractor.

#### XXII. Subcontractor Status

- A. If Contractor intends to subcontract any part of the services provided under this Contract to a separate and independent agency or agencies, it must submit a written Memorandum of Understanding (MOU) with that agency or agencies with original signatures to DBH. The MOU must clearly define the following:
  - 1. The name of the subcontracting agency.
  - 2. The amount (units, minutes, etc.) and types of services to be rendered under the MOU.
  - 3. The amount of funding to be paid to the subcontracting agency.
  - 4. The subcontracting agency's role and responsibilities as it relates to the Contract.
  - 5. A detailed description of the methods by which the Contractor will insure that all subcontracting agencies meet the monitoring requirements associated with funding regulations.
  - 6. A budget sheet outlining how the subcontracting agency will spend the allocation.

Any subcontracting agency must be approved in writing by DBH and shall be subject to all applicable provisions of this Contract. The Contractor will be fully responsible for any performance of a subcontracting agency. DBH will not reimburse Contractor or Subcontractor for any expenses rendered by a subcontractor NOT approved in writing by DBH.

- B. Ineligible Persons

Contractor shall adhere to Licensing and Certification Section XIII, Subsection F regarding Ineligible Persons or Excluded Parties for its subcontractors.

### XXIII. Attorney Costs and Fees

If any legal action is instituted to enforce any party's rights hereunder, each party shall bear its own costs and attorneys' fees, regardless of who is the prevailing party. This paragraph shall not apply to those costs and attorney fees directly arising from a third-party legal action against a party hereto and payable under Article XXIV Indemnification and Insurance Part A.

### XXIV. Indemnification and Insurance

#### A. Indemnification

The Contractor agrees to indemnify, defend (with counsel reasonably approved by County) and hold harmless the County and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this contract from any cause whatsoever, including the acts, errors or omissions of Contractor its officers, agents, employees or volunteers and for any costs or expenses incurred by the County on account of any claim except where such indemnification is prohibited by law. This indemnification provision shall apply regardless of the existence or degree of fault of indemnitees. The Contractor's indemnification obligation applies to the County's "active" as well as "passive" negligence but does not apply to the County's "sole negligence" or "willful misconduct" within the meaning of Civil Code Section 2782.

#### B. Additional Insured

All policies, except for the Workers' Compensation, Errors and Omissions and Professional Liability policies, shall contain endorsements naming the County and its officers, employees, agents and volunteers as additional insured with respect to liabilities arising out of the performance of services hereunder. The additional insured endorsements shall not limit the scope of coverage for the County to vicarious liability but shall allow coverage for the County to the full extent provided by the policy. Such additional insured coverage shall be at least as broad as Additional Insured (Form B) endorsement form ISO, CG 2010.11 85.

#### C. Waiver of Subrogation Rights

The Contractor shall require the carriers of required coverages to waive all rights of subrogation against the County, its officers, employees, agents, volunteers, contractors, and subcontractors. All general or auto liability insurance coverage provided shall not prohibit the Contractor and Contractor's employees or agents from waiving the right of subrogation prior to a loss or claim. The Contractor hereby waives all rights of subrogation against the County.

#### D. Policies Primary and Non-Contributory

All policies required herein are to be primary and non-contributory with any insurance or self-insurance programs carried or administered by the County.

#### E. Severability of Interests

The Contractor agrees to ensure that coverage provided to meet these requirements is applicable separately to each insured and there will be no cross liability exclusions that preclude coverage for suits between the Contractor and the County or between the County and any other insured or additional insured under the policy.

F. Proof of Coverage

The Contractor shall furnish Certificates of Insurance to the County Department administering the contract evidencing the insurance coverage, including endorsements, as required, prior to the commencements of performance of services hereunder, which certificates shall provide that such insurance shall not be terminated or expire without thirty (30) days written notice to the Department, and Contractor shall maintain such insurance from the time Contractor commences performance of services hereunder until the completion of such services. Within fifteen (15) days of the commencement of this contract, the Contractor shall furnish a copy of the Declaration page for all applicable policies and will provide complete certified copies of the policies and endorsements immediately upon request.

G. Acceptability of Insurance Carrier

Unless otherwise approved by Risk Management, insurance shall be written by insurers authorized to do business in the State of California and with a minimum "Best" Insurance Guide rating of "A-VII".

H. Deductibles and Self-Insured Retention

Any and all deductibles or self-insured retentions in excess of \$10,000 shall be declared to and approved by Risk Management.

I. Failure to Procure Coverage

In the event that any policy of insurance required under this contract does not comply with the requirements, is not procured, or is canceled and not replaced, the County has the right but not the obligation or duty to cancel the contract or obtain insurance if it deems necessary and any premiums paid by the County will be promptly reimbursed by the Contractor or County payments to the Contractor will be reduced to pay for County purchased insurance.

J. Insurance Review

Insurance requirements are subject to periodic review by the County. The Director of Risk Management or designee is authorized, but not required, to reduce, waive or suspend any insurance requirements whenever Risk Management determines that any of the required insurance is not available, is unreasonably priced, or is not needed to protect the interest of the County. In addition, if the Department of Risk Management determines that heretofore unreasonably priced or unavailable types of insurance coverage or coverage limits become reasonably priced or available, the Director of Risk Management or designee is authorized, but not required, to change the above insurance requirements to require additional types of insurance coverage or higher coverage limits, provided that any such change is reasonable in light of

past claims against the County, inflation, or any other item reasonably related to the County's risk.

Any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to this contract. Contractor agrees to execute any such amendment within thirty (30) days of receipt.

Any failure, actual or alleged, on the part of the County to monitor or enforce compliance with any of the insurance and indemnification requirements will not be deemed as a waiver of any rights on the part of the County.

K. Insurance Specifications

The Contractor agrees to provide insurance set forth in accordance with the requirements herein. If the Contractor uses existing coverage to comply with these requirements and that coverage does not meet the specified requirements, the Contractor agrees to amend, supplement or endorse the existing coverage to do so. The type(s) of insurance required is determined by the scope of the contract services.

Without in anyway affecting the indemnity herein provided and in addition thereto, the Contractor shall secure and maintain throughout the contract term the following types of insurance with limits as shown:

1. Worker's Compensation/Employers Liability – A program of Workers' Compensation insurance or a state-approved, self-insurance program in an amount and form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability with \$250,000 limits covering all persons including volunteers providing services on behalf of the Contractor and all risks to such persons under this contract.

If Contractor has no employees, it may certify or warrant to the County that it does not currently have any employees or individuals who are defined as "employees" under the Labor Code and the requirement for Worker's Compensation coverage will be waived by the County's Director of Risk Management.

With respect to Contractors that are non-profit corporations organized under California or Federal law, volunteers for such entities are required to be covered by Worker's Compensation insurance.

2. Commercial/General Liability Insurance – The Contractor shall carry General Liability Insurance covering all operations performed by or on behalf of the Contractor providing coverage for bodily injury and property damage with a combined single limit of not less than one million dollars (\$1,000,000), per occurrence. The policy coverage shall include:
  - a. Premises operations and mobile equipment.
  - b. Products and completed operations.

- c. Broad form property damage (including completed operations)
- d. Explosion, collapse and underground hazards.
- e. Personal Injury
- f. Contractual liability
- g. \$2,000,000 general aggregate limit

3. Automobile Liability Insurance – Primary insurance coverage shall be written on ISO Business Auto coverage form for all owned, hired and non-owned automobiles or symbol 1 (any auto). The policy shall have a combined single limit of not less than one million dollars (\$1,000,000) for bodily injury and property damage, per occurrence.

If the Contractor is transporting one or more non-employee passengers in performance of contract services, the automobile liability policy shall have a combined single limit of two million dollars (\$2,000,000) for bodily injury and property damage per occurrence.

If the Contractor owns no autos, a non-owned auto endorsement to the General Liability policy described above is acceptable.

4. Umbrella Liability Insurance – An umbrella (over primary) or excess policy may be used to comply with limits or other primary coverage requirements. When used, the umbrella policy shall apply to bodily injury/property damage, personal injury/advertising injury and shall include a “dropdown” provision providing primary coverage for any liability not covered by the primary policy. The coverage shall also apply to automobile liability.

#### L. Professional Services Requirements

1. Professional Liability – Professional Liability Insurance with limits of not less than one million (\$1,000,000) per claim or occurrence and two million (\$2,000,000) aggregate limits

Or

Errors and Omissions Liability Insurance – Errors and Omissions Liability Insurance with limits of not less than one million (\$1,000,000) and two million (\$2,000,000) aggregate limits

Or

Directors and Officers Insurance – Directors and Officers Insurance coverage with limits of not less than one million (\$1,000,000) shall be required for Contracts with charter labor committees or other not-for-profit organizations advising or acting on behalf of the County.

2. If insurance coverage is provided on a “claims made” policy, the “retroactive date” shall be shown and must be before the date of the start of the contract

work. The “claims made” insurance shall be maintained or “tail” coverage provided for a minimum of five (5) years after contract completion.

#### XXV. Nondiscrimination

- A. General. Contractor agrees to serve all patients without regard to race, color, sex, religion, national origins or ancestry pursuant to the Civil Rights Act of 1964, as amended (42 USCA, Section 2000 D), and Executive Order No. 11246, September 24, 1965, as amended.
- B. Handicapped. Contractor agrees to comply with the Americans with Disabilities Act of 1990 (42 U.S.C. 1202 et seq.) which prohibits discrimination on the basis of disability, as well as all applicable Federal and State laws and regulations, guidelines and interpretations issued pursuant thereto.
- C. Employment and Civil Rights. Contractor agrees to and shall comply with the County's Equal Employment Opportunity Program and Civil Rights Compliance requirements:

- 1. Equal Employment Opportunity Program: The Contractor agrees to comply with the provisions of the Equal Employment Opportunity Program of the County of San Bernardino and rules and regulations adopted pursuant thereto: Executive Order 11246, as amended by Executive Order 11375, 11625, 12138, 12432, 12250, Title VII of the Civil Rights Act of 1964 (and Division 21 of the California Department of Social Services Manual of Policies and Procedures and California Welfare and Institutions Code, Section 10000), the California Fair Employment and Housing Act, and other applicable Federal, State, and County laws, regulations and policies relating to equal employment or social services to welfare recipients, including laws and regulations hereafter enacted.

The Contractor shall not unlawfully discriminate against any employee, applicant for employment, or service recipient on the basis of race, color, national origin or ancestry, religion, sex, marital status, age, political affiliation or disability. Information on the above rules and regulations may be obtained from County DBH Contracts Unit.

- 2. Civil Rights Compliance

The Contractor shall develop and maintain internal policies and procedures to assure compliance with each factor outlined by State regulation. Consistent with the requirements of applicable federal 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 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. The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to per work under this contract. Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to Title 9, CCR, Section 1820.205 Section 1830.205 or Section 1830.210, prior to providing covered services to a beneficiary.

#### XXVI. Contract Amendments

Contractor agrees any alterations, variations, modifications, or waivers of provisions of the Contract shall be valid only when they have been reduced to writing, duly signed by both parties and attached to the original of the Contract and approved by the required persons and organizations.

#### XXVII. Assignment

- A. This agreement shall not be assigned by Contractor, either in whole or in part, without the prior written consent of the Director.
- B. This contract and all terms, conditions and covenants hereto shall inure to the benefit of, and binding upon, the successors and assigns of the parties hereto.
- C. If the ownership of the Contractor changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the State and County with written documentation stating:
  - 1. That the new licensee shall have custody of the patients' records and that these records or copies shall be available to the former licensee, the new licensee and the County; or
  - 2. That arrangements have been made by the licensee for the safe preservation and the location of the patients' records, and that they are available to both the new and former licensees and the County; or
  - 3. The reason for the unavailability of such records.

#### XXVIII. Environmental Requirements

In accordance with County Policy 11-10, the County prefers to acquire and use products with higher levels of post-consumer recycled content. To assist the County in meeting the reporting requirements of the California Integrated Waste Management Act of 1989 (AB939), Contractor must be able to annually report the County's environmentally preferable purchases using Attachment X. Service providers are asked to report on environmentally preferable goods and materials used in the provision of their services to the County.

XXIX. Venue

The venue of any action or claim brought by any party to the Contract will be the Superior Court of California, County of San Bernardino, San Bernardino District. Each party hereby waives any law or rule of the court, which would allow them to request or demand a change of venue. If any action or claim concerning the Contract is brought by any third-party and filed in another venue, the parties hereto agree to use their best efforts to obtain a change of venue to the Superior Court of California, County of San Bernardino, San Bernardino District.

XXX. Conclusion

- A. This agreement consisting of thirty-three (33) pages, Addendum I, and Attachments I, II, III, IV, V, VI, VII, VIII, IX and X inclusive is the full and complete document describing the services to be rendered by Contractor to County, including all covenants, conditions and benefits.
- B. This agreement supersedes any and all agreements that may exist between the Contractor and the County.
- C. IN WITNESS WHEREOF, the Board of Supervisors of the County of San Bernardino has caused this agreement to be subscribed by the Clerk thereof, and Contractor has caused this agreement to be subscribed on its behalf by its duly authorized officers, the day, month, and year first above written.

COUNTY OF SAN BERNARDINO

►  
\_\_\_\_\_  
Josie Gonzales, Chair, Board of Supervisors

Dated: \_\_\_\_\_

SIGNED AND CERTIFIED THAT A COPY OF THIS  
DOCUMENT HAS BEEN DELIVERED TO THE  
CHAIRMAN OF THE BOARD

Laura H. Welch  
Clerk of the Board of Supervisors  
of the County of San Bernardino

By \_\_\_\_\_  
Deputy

\_\_\_\_\_  
(Print or type name of corporation, company, contractor, etc.)

By ►  
\_\_\_\_\_  
(Authorized signature - sign in blue ink)

Name \_\_\_\_\_  
(Print or type name of person signing contract)

Title \_\_\_\_\_  
(Print or Type)

Dated: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Approved as to Legal Form

►  
\_\_\_\_\_  
Frank Salazar, Deputy County Counsel

Date \_\_\_\_\_

Reviewed by Contract Compliance

►  
\_\_\_\_\_

Date \_\_\_\_\_

Presented to BOS for Signature

►  
\_\_\_\_\_  
Department Head

Date \_\_\_\_\_

Fee For Service  
Acute Psychiatric Inpatient Services

SERVICE(S) DESCRIPTION

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COUNTY OF SAN BERNARDINO

**I. Definition Of Recovery, Wellness, and Discovery and Rehabilitative Mental Health Services**

- A. The Mental Health Wellness/Discovery focus and rehabilitative mental health services include the concepts of recovery and resilience. “Recovery” refers to the process in which people are able to live, work, learn, and participate fully in their communities. “Resilience” means the personal qualities that enable a person to rebound from adversity, trauma, tragedy, threats, or other stresses, and to go on with life with a sense of mastery, competence, and hope. “Rehabilitation” is a strength-based approach to skills development that focuses on maximizing an individual’s functioning. Mental health services should support the individual in accomplishing his/her desired results. Program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community, which the program serves. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual’s needs and desires, and facilitating the individual’s choices and responsibilities. Programs may be designed to use both licensed and non-licensed personnel who are experienced in providing mental health services and behavioral interventions. Science has shown that having hope plays an integral role in the individual’s recovery process.

**II. Program Description**

Historically, public mental health services in California have been reimbursed under two separate systems: Short-Doyle/Medi-Cal (county operated services) and Fee-for-Service Medi-Cal (private hospitals and practitioners). On January 1, 1995, these two systems were consolidated into a single, integrated service delivery system for psychiatric inpatient services. This single system is administered through the County of San Bernardino, Department of Behavioral Health (DBH), which acts as the Local Managed Mental Health Plan Agency (MHP). DBH/MHP has the responsibility for administering the Plan and managing the funds allocated by the State for all Medi-Cal acute inpatient psychiatric services within the County. The MHP authorizes all Medi-Cal reimbursement for psychiatric inpatient services based on medical necessity. MHP also serves as a resource to private psychiatric hospitals, providing consultation on residential care and community support services.

**III. Admission Criteria:**

- A. Pre-entry

Patients must be medically cleared prior to being admitted. All patients admitted to an acute care psychiatric facility are assumed to be medically clear.

**B. Medi-Cal Eligibility and County of Residence Determination**

1. Contractor is required to determine the Medi-Cal status of all patients being admitted to its facility. Contractor staff are to make a diligent effort to determine a patient's Medi-Cal status using a Point of Service device (POS) and/or by contacting the closest Social Security Office and/or by contacting the Medi-Cal office at (800) 952-5253. If staff still have problems properly identifying a patient's Medi-Cal status, they are to contact the County DBH Financial Interviewers Office at (909) 382-3097 for consultation. All efforts to determine Medi-Cal eligibility are to be well documented in patient charts. Contractor will only be able to bill a patient's Medi-Cal county of residence for services. No reimbursement will be given to a Contractor by a county for a Medi-Cal patient from another county, and in no event will any reimbursement be given unless the 24-hour notification, and 14-day post-discharge Treatment Authorization Request (TAR) requirement (or, for the Indigent Care Services Program, the 45-day post-discharge UB92 requirement) are met as described in Section III. F. of this Addendum.

2. Pending Eligibility/Retroactive Eligibility

In all cases where Medi-Cal is granted retroactively, the Contractor is to submit the TAR after Medi-Cal has been granted, indicating on the TAR that Medi-Cal was granted retroactively. The 24-hour notification requirement of Paragraph III, B. 1. shall not apply in these cases.

3. Other Insurance

In all cases where there are other primary and secondary insurances, including Medicare, these sources are to be billed prior to Medi-Cal billing.

4. Uncertain County of Beneficiary Status

A patient's county of beneficiary status is to be determined in the same fashion as in Section II. B.-1 (i.e., using the POS device, contacting Social Security, contacting the Medi-Cal office, or by consulting DBH Financial Evaluation Section as a last resort). However, if a patient's county of beneficiary cannot be identified, Contractor is to provide San Bernardino County MHP with a completed 24-Hour Notification form and POS print-out, within 24-hours of admission.

TARs submitted to San Bernardino County MHP for reimbursement must be submitted within 14-days of discharge. UB-92s for the Indigent Care Services Program must be submitted within 45 days of discharge.

5. Identity Unknown

If a patient's identity cannot be established, the local Sheriff's substation is to be contacted to have the patient's finger prints taken and examined. If a patient's identity cannot be determined, the San Bernardino County MHP Authorization Unit is to be contacted within twenty-four (24) hours of admission.

**C. Medical Necessity**

Medical necessity for inpatient psychiatric hospital care is defined by the presence of a covered mental condition manifested by acute symptoms of sufficient severity that the absence of immediate mental health services could reasonably be expected to result in a patient's health being placed in jeopardy, and/or the patient being a danger to self and/or to others, (i.e., services are needed to protect life or treat significant disability). Medical necessity never implies entitlement to a specific level of care, type of service, or specific service location. The appropriate service for an individual is always based on clinical judgment. Thus, the admission criteria listed herein do not entitle a person to receive Inpatient Services. It is the presence of an included diagnosis, a functional impairment, and documentation that the patient cannot be treated at a lower level of care that are required to meet admission criteria. Once it is determined the individual has a covered diagnosis, it is the severity of the functional impairment and evidence that the patient cannot be treated at a lower level of care that ultimately qualify a service for reimbursement.

In order for acute services to be reimbursed, a patient must have been seen and evaluated by a psychiatrist and the patient's condition must meet ALL of the following criteria (i.e., 1 and 2).

1. Patient must have a valid DSM IV principal admitting diagnosis in one of the following categories:
  - a. Pervasive Developmental Disorders (except autism)
  - b. Disruptive Behavior & Attention Deficit Disorders
  - c. Feeding and Eating Disorders of Infancy or Early Childhood
  - d. Tic Disorders
  - e. Elimination Disorders
  - f. Other Disorders of Infancy, Childhood or Adolescence;
  - g. Cognitive Disorders (Only Dementias With Delusions or Depressed Mood)
  - h. Substance Induced Disorders, Only with Psychotic, Mood, or Anxiety Disorder
  - i. Schizophrenia and Other Psychotic Disorders
  - j. Mood Disorders

- k. Anxiety Disorders
  - l. Somatoform Disorders
  - m. Dissociative Disorders
  - n. Eating Disorders
  - o. Intermittent Explosive Disorder
  - p. Pyromania
  - q. Adjustment Disorders
  - r. Personality Disorders
2. Patient cannot be safely treated at another level of care, [i.e., lower levels of treatment have been attempted and have failed to remedy the patient's acute symptoms or reasons why less restrictive service resource(s) are inappropriate have been documented by the admitting or evaluating physician], and requires voluntary or involuntary admission due to the following (must have "a" or "b"):
- a. Has symptoms or behaviors that meet one of 1), 2), or 3), below:
    - 1) Presents a severe risk to physical health, is a current danger to self, or others, or is a threat to engage in significant property destruction as exemplified by the following: a recent suicide attempt, OR active suicidal threat(s) with a deadly plan, AND there is absence of appropriate supervision or structure to prevent suicide; a recent self-mutilative behavior (i.e., intentionally cutting or burning self) OR active threats of same with likelihood of acting on the threat, AND there is an absence of appropriate supervision or structure to prevent self-mutilation; an active hallucination(s) or delusion(s) directing or likely to lead to serious self-harm; recent serious assaultive behavior or sadistic behavior or active threat(s) of same with likelihood of acting on the threat(s), AND there is an absence of appropriate supervision or structure to prevent assaultive behavior.
    - 2) Prevents the individual from providing for, or utilizing, food, clothing, or shelter.
- [Note: An individual is not considered unable to provide for basic needs, even if (s)he meets the above criteria, if (s)he has responsible friends, family, or others who indicate their willingness (must be documented) to care for the individual and the individual is able and willing to take advantage of

these resources. Services rendered to patients meeting this description will not be reimbursed.]

- 3) Represents a recent, significant deterioration in ability to function.
- b. Requires admission for treatment and/or observation for either 1) or 2) below:
  - 1) further psychiatric evaluation
  - 2) medication treatment
3. The psychiatric condition must reflect the above criteria and be documented in the patient's chart.

**D. Continued Stay**

1. Approval of payment for a patient's hospital stay will be predicated upon documentation of one or more of the following criteria:
  - a. A patient's meeting and continuing to meet medical necessity criteria.
  - b. A patient's serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
  - c. The presence of new indicators which meet admission criteria described above.
  - d. Patient requires continuous medical evaluation/treatment that can only be provided if the patient remains in a 24-hour inpatient unit.
  - e. The treatment services provided meet standard of care for inpatient medical services as determined by MHP staff.
2. The provision of services must be reasonably expected to improve the patient's condition so that a lower level of care can be implemented following stabilization.
3. Contractor shall provide appropriate and timely discharge and aftercare planning for all admitted patients. The Contractor will identify a unit of qualified social workers/discharge planners who will consult with MHP staff to formulate and implement discharge plans and to link patients to appropriate aftercare placement resources. All discharge plans must be documented by the Contractor (i.e. any and all appropriate aftercare referrals).
4. Administrative Days
  - a. For Medi-Cal beneficiaries only, administrative day reimbursement will be awarded when the patient's stay must be continued beyond the patient's need for acute care due to the lack of residential

placement options at appropriate, non-acute treatment facilities and the patient's stay previously met medical necessity criteria. For further clarification, please see Article I Definition of Terminology Paragraph C. of this Agreement; see also Attachment I regarding DBH Contracted facilities requiring referrals through DBH.

- b. To qualify for "Administrative Days" reimbursement for:
  - 1) Patients 18 years or older, Contractor will be responsible for contacting and documenting, at least once each five working days, all qualifying appropriate residential placement options (non-acute treatment facilities) within a sixty (60) mile radius until the patient is placed, or Medi-Cal reimbursement is no longer expected (i.e. patient no longer requires non-acute level of care).
  - 2) Patients under 18 years of age and who are connected to a county agency which may facilitate placement [i.e., Probation, CFS, and Adoptions Assistance Program], Contractor will be responsible for contacting and documenting at least once each five days contact with the representative from the county agency and the placements which have been considered.

Contractor is advised that patients who have been approved for residential placement through special education [i.e., AB2726 (DBH)] continue to be the responsibility of their guardians and, as such, should be discharged to their care when no longer requiring hospitalization. Therefore, the inability to locate a residential placement through AB2726 does not justify administrative days.
- c. Documentation will be made in patient chart of contacts to non-acute treatment facilities each time a facility is contacted, with a brief description of the status, the name and location of the facility contacted and the signature of the person making the contact. When non-medical staff are responsible for making the placement contacts, the documentation produced by these individuals should be included with the patient's chart when it is submitted to the MHP for review for payment. See Section "e" below for additional details on documentation requirements.
- d. Administrative Day Services is defined in Title 9, California Code of Regulations (CCR) Section 1701 as " Services authorized by a Mental Health Plan's Point of Authorization or a Short-Doyle/Medi-

Cal provider's Utilization Review Committee that is acting as a Point of Authorization, for a beneficiary residing in a psychiatric inpatient hospital when, due to a lack of residential placement options at appropriate, non-acute treatment facilities as identified by the Mental Health Plan, the beneficiary's stay at the psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services." During the hospital stay, the beneficiary must also have met the medical necessity criteria for acute psychiatric inpatient hospital services.

The San Bernardino County Mental Health Plan has identified the following as Medi-Cal eligible non-acute treatment facilities that meet the Administrative Day Service criteria:

- 1) State Hospital;
- 2) Skilled Nursing facilities with a psychiatric component;
- 3) Institutes for Mental Disease;
- 4) Licensed augmented board and care facilities. These are designated board and care facilities that have a contract with DBH to provide specialized enhanced services to targeted populations. Non-augmented licensed board and care facilities do not qualify for administrative day reimbursement;
- 5) Group Home with an RCL rating of 10 or above or placement into qualified Wraparound Services as approved by the San Bernardino County Interagency Placement Council (the case manager from the county placing agency should be involved to determine that the level of placement is clinically appropriate).

- e. Chart documentation requirements for administrative day service per the San Bernardino Mental Health Plan:

The lack of placement options at appropriate non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include, but not limited to, the following:

- 1) The status of the placement option. Document in the chart note the level, type and name of placement facility contacted and the disposition of each contact.
- 2) Date of the contact and name and title of the person contacted.
- 3) Signature and title of the person making the contact.

- 4) In cases where Contractor cannot make direct contact with potential facilities because there is a DBH case manager who functions as a placement gatekeeper, the Contractor is responsible for obtaining copies of the gatekeeper's placement effort documentation and to include this documentation with the chart when it is submitted to the MHP for consideration for payment.

According to Title 9 requirements, the Contractor must document contacts with a minimum of five appropriate, non-acute treatment facilities per week. The DBH Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary and there is sufficient documentation to support this. In no case shall there be less than one documented contact per week.

**E. Quality Management**

1. Contractor shall comply with requirements for utilization review pursuant to Title 42, CFR, Subpart D. Compliance shall include documentation of medical necessity, appropriateness of the level of care, and duration of services.
2. Contractor will establish a Utilization Review Committee (URC) whose function will be to determine that admissions and length of stay are appropriate to level of care and to ensure that MHP admission and continued stay criteria are met. Composition of the committee shall meet minimum federal requirements. A log shall be maintained, recording the date and outcome of each review, the patient's name, chart number, as well as the signature of the reviewer.
3. All Contractor Quality Management/Utilization Review records will be made available for review by MHP staff upon request.
4. Contractor's URC will take into account functioning level and utilization of other available resources when evaluating need for inpatient service upon admission and throughout the continued stay. Services which do not meet the minimum standards for medical necessity/least restrictive level of care are non-reimbursable.
5. MHP Authorization and Quality Improvement staff will be available to educate providers to ensure that federal URC requirements are met and that each provider's URC is familiar with the expectations of MHP in terms of quality and reimbursement issues. Contractor will be subject to MHP Quality Management Committee oversight. Quality care may be measured via performance outcome measures, other focused studies,

audits, routine reviews, or other methods as determined necessary by MHP.

6. Quality of care provided to patients by the Contractor will meet MHP standards of inpatient care. Compliance will be assessed as part of the MHP payment authorization review process.

7. On-site Reviews

MHP and the State Department of Mental Health shall conduct periodic audits, including on-site audits, of performance under this Agreement. These audits may include a review of the following:

- a. Level and quality of care, as well as the necessity and appropriateness of the services provided.
- b. Internal procedures for assuring efficiency, economy and quality of care.
- c. Compliance with MHP Patient Grievance Procedures.
- d. Financial records when determined necessary to protect public funds.

F. Authorization for Reimbursement

1. All required documentation supporting the indigent care reimbursement process must be submitted to the San Bernardino County Department of Behavioral Health Point of Authorization within 45 days of the date of discharge. The dates of the hospitalization must be within the current fiscal year, which is July 1 to June 30. Funding is subject to availability and contractual limits. Any unspent fiscal year allocation does not roll over and is not available in future years. The Department of Behavioral Health will not reconsider a claim for indigent care which has previously been denied.

Contractor will notify MHP Authorization Unit of all admissions for which Medi-Cal reimbursement may reasonably be expected within 24 hours of admission, via the "24-Hour Notification Form," and, to the extent feasible, provide MHP with identifying data and intake information as requested by MHP. **24-Hour Notifications are to be faxed to the MHP Authorization Unit at (909) 873-4441.**

2. Reimbursement Categories

- a. For the general population, the Contractor shall send proof of Medi-Cal eligibility with each 24-Hour Notification sent to the MHP Authorization Unit, when applicable. Contractor shall submit supporting documentation for pending Medi-Cal eligibility. This documentation may be provided by the client or may be available to Contractor through the State Medi-Cal system.

- b. When a minor from one of the San Bernardino County juvenile detention facilities is admitted to a Fee-For-Service psychiatric inpatient hospital which participates in the Indigent Care Services Program administered by the San Bernardino County Department of Behavioral Health, that hospital will not be required to submit an “Application for Reimbursement of Treatment to Medically Indigent Child in Contract Hospital.” All of the other requirements of the Indigent Care Services Program, however, will apply.
- 3. Reimbursement for services is contingent upon the Contractor meeting regulatory/licensing criteria.
- 4. Authorization for Reimbursement is the process utilized by MHP to ensure that patients receive the appropriate type and amount of services needed. Non-compliance with standards of inpatient care as determined by MHP will result in non-reimbursement of services. The absence of a daily progress note by a psychiatrist will result in nonpayment.
- 5. The Contractor will be responsible for providing authorized MHP representatives with access to patients' records and consistent face-to-face access to all patients for whom the Contractor has submitted a 24-Hour Notification for an inpatient admission. Contractor will not be reimbursed for services rendered to patients if MHP staff have been prevented from interviewing them. Claims denied due to denial of patient access may not be appealed to the State. Reimbursement for services rendered to patients prior to MHP staff being denied an interview will be determined by medical necessity via MHP payment authorization review process.
- 6. Some planned admissions will be authorized with prior approval by MHP Authorization Unit staff. However, planned admissions are severely limited (e.g., for Electroconvulsive Treatment, some FDA approved medication trials, etc.)
- 7. Some services may be authorized/approved concurrently upon approval of MHP Authorization Unit staff.
- 8. Authorization for reimbursement will be by an oversight review process. MHP staff will conduct case reviews retrospectively (in most cases) on an ongoing basis for the purpose of approval/denial of reimbursement. Reviews may include on-site, telephone review, review of Faxed documentation, or documentation sent to MHP via mail. The specific method(s) of review will be determined by MHP.
- 9. Contractor will be responsible for submission of Treatment Authorization Requests (TARs) to MHP within 14 days of discharge on all cases in which Medi-Cal reimbursement is requested per Title 9. UB-92s requesting payment through the Indigent Care Services Program must be

submitted within 45 days of discharge. All TARs and UB-92s should be sent to the following location within referenced timelines:

**FOR SPECIAL DELIVERIES:**

**Department of Behavioral Health  
ATTN: Inpatient Authorization Unit  
850 E. Foothill Boulevard  
Rialto, CA 92376**

**FOR REGULAR MAIL:**

**Department of Behavioral Health  
ATTN: Inpatient Authorization Unit  
P. O. Box 2610  
San Bernardino, CA 92406-2610**

10. Additional off-site or on-site review of records may be conducted periodically as part of MHP's Quality Management Committee oversight function.
11. A day of service shall be billed for each beneficiary who meets admission and/or continued stay criteria, documentation requirements, treatment and discharge planning requirements, and occupies a psychiatric inpatient hospital bed at 12:00 midnight in the contract facility. However, a day of service may be billed if the beneficiary is admitted and discharged during the same day, provided that such admission and discharge is not within 24 hours of a prior discharge.
12. The Contractor shall bear total risk for the cost of all psychiatric inpatient hospital services rendered to each Medi-Cal beneficiary covered by the Agreement.
13. Payment to the Contractor shall equal the negotiated rate per day, less any third party liability and shall not be subject to adjustments.
14. Under Fee-For-Service Acute Psychiatric Hospital Medi-Cal Consolidation, eligible Medi-Cal beneficiaries will receive inpatient mental health services consistent with standards set by the State and in accordance with Federal Medicaid requirements. The San Bernardino

County Department of Behavioral Health is the State-designated Local Mental Health Plan responsible for authorizing or denying Fee-For-Service Medi-Cal payment.

MHP clinicians, in accordance with the Federal (HCFA) Freedom of Choice waiver, relative to Section 1902(a)(23) of the Social Security Act, may initiate voluntary and/or involuntary transfer to alternative treatment sites as determined by MHP and in compliance with the Federal (HCFA) Freedom of Choice waiver granted to the State of California relative to Section 1902(a)(23) of the Social Security Act. Reimbursement will be denied for patients who refuse a voluntary transfer stipulated by MHP representatives as an alternative treatment source. The "MHP Transfer Form" provided to the FFS hospital will indicate the date beyond which payment will not be authorized.

Reimbursement for services rendered to patients prior to transfer stipulation will be determined by medical necessity via MHP payment authorization review process.

**IV. Confidentiality Guidelines**

- A. Contractor will maintain all patient information and patients' records as part of one integrated service delivery system. The Contractor will release all information and records to MHP representatives as permitted or required by law. Information shall remain confidential as referenced in the W & I Code.
- B. Contractor shall have a written procedure for release of information which shall be consistent with the requirements set forth in State and Federal laws and regulations.
- C. Patient information and records shall be confidential and can only be released to agencies other than MHP with the patient's written permission, or as otherwise permitted by law. To the extent required by law, a signed patient release of information form will be used to authorize the exchange of patient information. The form will be specific in identifying the information that the agency requires.

**V. Quality of Care**

- A. Contractor will assure that all Medi-Cal beneficiaries receive care as specified in the Agreement.
- B. Contractor shall provide psychiatric inpatient hospital services in the same manner to Medi-Cal beneficiaries as they are provided to all other patients.
- C. Contractor shall not discriminate against Medi-Cal beneficiaries in any manner, including admission practices, placement in special wings or rooms, or the provision of special or separate meals.
- D. Contractor shall provide the same standard of medical care as in the community, i.e. performing basic laboratory work upon admission, completing history and

physical examinations within 24 hours of admission, determining blood levels of medications as indicated, e.g. Tegretol, Dilantin, Depakote, etc.

- E. When quality of care issues are identified by MHP staff, the issues will be referred to the MHP Quality Improvement Coordinator for referral to the appropriate Quality Management standing committee. The appropriate MHP standing committee will review each referral and request a plan of correction, if indicated.

## **VI. Outcome Evaluations**

- A. The MHP will conduct ongoing assessments of outcomes achieved by the patients served by the Contractor. Outcomes include what the patient is able to achieve based on his stated goals and abilities with the help of services provided by the Contractor and/or MHP. Variables such as financial status, living arrangements, educational goals, functioning, social and support networks prior to, and/or during receipt of services may be examined. Symptom reduction and prevention of recidivism to higher levels of care may be used to measure outcomes.
- B. The MHP will focus on a few important outcomes which are goals of the managed care system. Achievement of these goals will be monitored carefully to determine whether the program is functioning appropriately to allow achievement of these goals. The primary focus will be on concrete, measurable, and behavioral indications of functioning.
- C. Assessment of outcomes is based upon comparisons with previous performance, with current established standards, with established practices and other available information. Intensive assessment followed by remedial action is warranted when undesirable variation in performances has been identified.

## **VII. Patient Satisfaction**

Patient satisfaction is a critical component of the quality of services provided by the Contractor. Periodically, patient satisfaction surveys will be distributed to patients by MHP to assess patient satisfaction with the services provided by the Contractor. The surveys are designed to accommodate language and cultural differences among patients and will be offered in the patient's primary language whenever possible. Survey questions will address the uniqueness of each age group (children, adolescents, adults, and older adults). Comments from the patient's family members and/or significant others, will also be taken into consideration. These surveys shall address various aspects of service delivery which include access to service, waiting times, courtesy of staff and level of information provided concerning their illness. The patient satisfaction surveys will also be used as measures to determine future service planning and to ensure that services are developed to meet the needs and desires of the Contractor's patients.

## **VIII. Cultural and Linguistic Requirements**

**A. Definitions:**

1. "Key points of contact" means common points of access to specialty mental health services from the Mental Health Plan (MHP), including but not limited to the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.
2. "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.
3. "Threshold Language" means a language that has been identified as the primary language, as indicated on the MEDS, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

**B. Each MHP shall have:**

1. Oral interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:
  - a. The MHP has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and
  - b. The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.
2. Policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the specialty mental health services or related services available through that key point of contact.
3. General program literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure required by Section 1810.360(c), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and mental health education materials used by the MHP,

in threshold languages, based on the threshold languages in the county as a whole.

4. Make appropriate auxiliary aids and services available to ensure effective communication for Deaf, Hard of Hearing, and Blind, as required of private entities via Title III of ADA (28 C.F.R. §§ 35.104, 35.160).
5. A qualified interpreter available when one is requested by a person who is deaf or hard of hearing, as defined per C.F.R. §§ 35.104

**IX. Miscellaneous Contractor Responsibilities**

The Contractor shall:

- A. Accept into an available and appropriately licensed bed, any Medi-Cal eligible patients referred to its facility who meet target inpatient medical necessity as outlined in this Addendum.
- B. Transport patients to Contract hospital from non-contract hospital when feasible. Provide necessary transportation to return patients back to San Bernardino County place of residence. When transportation services are Medi-Cal eligible, they shall be billed separately from the per diem rate for Psychiatric Inpatient Hospital Services. Costs associated with all other necessary transportation will be assumed by the Contractor under the negotiated per diem rate.
- C. Evaluate, admit and treat patients who meet the documented need for inpatient hospitalization in compliance with MHP admission and continued stay criteria.

The Fee-for-Service and the Short-Doyle/Medi-Cal Systems Admission Criteria are integrated under MHP and, as such, admission criteria at contract hospitals shall meet standards consistent with San Bernardino County MHP admission criteria. Designated 5150 treatment facilities shall be in compliance with the W & I Code regarding involuntary treatment. Contractor shall be in compliance with all other statutory and regulatory requirements. Findings of non-compliance and violations of patient's rights shall be forwarded by MHP representatives, and as appropriate, to the office of Patients' Rights.

- D. Provide and document appropriate and timely discharge and aftercare planning.
- E. Provide appropriate office space for MHP staff to perform patient interviews and to review written documentation on patients at the facility. Contractor will facilitate MHP staff interviews of all patients for whom the Contractor has submitted 24-Hour Notifications for an inpatient stay.
- F. Assist patients requesting release in completing the standard Request for Release form (writ) for patients who have been involuntarily detained (in hospitals with such capacity).
- G. Maintain pharmacy in compliance with all appropriate regulations and laws.

- H. Ensure that appropriate patients are recommended for temporary Conservatorship in consultation/coordination with DBH Conservatorship Investigator's Office at (909) 421-9380 or by making a needs assessment request.
- I. Provide discharged patients with all psychiatric medication (up to 14 days) and necessary equipment that the facility has on hand prescribed for that patient or with a sufficient prescription to last the patient (up to 14 days) or until his/her first outpatient medication appointment, whichever is sooner.
- J. Take appropriate steps to avoid readmission of patients to an acute level of psychiatric care by taking the following actions:
  - 1. Refer all appropriate patients for community aftercare services.
  - 2. Provide pertinent patient information to aftercare provider.
  - 3. Ensure that crisis intervention services have been provided prior to patients being considered for admission to acute inpatient hospital.

Patterns of readmission may be referred to MHP Quality Assurance Committee.

- K. Contractor will be expected to develop an appropriately structured treatment program. Multi-disciplinary teams will be in place in each facility to ensure that quality psychiatric care is provided to patients. This includes medications (i.e., administration, education, documentation of side effects and attempts to ameliorate, etc.), individualized treatment plans, consultation with support systems (e.g. family members) and patient safety.
- L. Consideration for special populations will be integrated into all aspects of the inpatient delivery system. The purpose of this is to assure equal access, equal treatment in the service delivery process, and consideration of special needs.

**X. Miscellaneous MHP Responsibilities**

MHP shall:

- A. Provide information and consultation to Contractor to assist hospital staff to implement discharge and aftercare plans. These services will be provided upon request by Contractor and when deemed appropriate by MHP staff.
- B. Educate Contractor as follows:
  - 1. Provide Contractor with information regarding community placement resources available to adults and youth.
  - 2. Provide Contractor with information regarding mental health community aftercare resources.
- C. Consult with Contractor:
  - 1. On criteria for patients being referred for placement into a MHP residential resource system.

2. On referrals to alternatives for service in the community.
3. On levels of care needed according to degree of impairment.
4. On current availability of community based residential system (e.g., group homes, Board and Care, Skilled Nursing Facilities, etc.).

D. Evaluate (upon referral from Contractor) for:

1. Adult (for admission to)
  - a. State Hospital
  - b. IMDs
  - c. Augmented Board and Cares (ABC).
2. Youth (for admission to)
  - a. Mental Health Intensive/Subacute program.
  - b. Mental Health Transitional group home program.

E. Placement:

1. When an individual is found to meet the appropriate criteria for any of the above placements, or is in need of case management (criteria to be supplied by DBH) a DBH referral/placement case manager is to be contacted by the Contractor (via the Managed Care Clinician) to coordinate placement arrangements and/or case management services, if appropriate as determined by MHP prior to discharge. Contractor shall not attempt to contact DBH contract residential providers directly to initiate placement.
2. Discharge coordination is to be accomplished via consultation (by telephone or face-to-face, depending upon the situation) between DBH Managed Care staff and Contractor staff. Contractor is to make appropriate staff available for these consultations.
3. Ongoing case management services for appropriate (as determined by MHP) select patients (criteria to be supplied by MHP) will be provided by MHP staff.

**MHP CHILD/ADOLESCENT CONTRACTED FACILITIES**

(Refer to Addendum I, Continued Stay, Administrative Days)

Contractor is responsible for contacting the local DBH outpatient clinic to request referral to the following approved facilities:

Victor Treatment Centers (Level 14)

**MHP ADULT CONTRACTED FACILITIES**

(Refer to Addendum I, Continued Stay, Administrative Days)

Contractor is responsible for contacting the local DBH outpatient clinic to request referral to the following approved facilities:

Metropolitan State Hospital  
Contracted Board and Care Home  
Shandin Hills Behavioral Therapy  
Braswell Enterprises, Inc. d.b.a. Sierra Vista  
Vista Pacifica

**SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH  
MAXIMUM OBLIGATION AND REIMBURSEMENT REQUIREMENTS  
FOR INDIGENT CARE SERVICES**

**I. MAXIMUM OBLIGATION**

The Aggregate Maximum Obligation of San Bernardino County for services provided in accordance with all agreements for Adult Mental Health Inpatient Services during the term of this Agreement is as specified on the Referenced Contract Provisions of this Agreement. This specific Agreement with Contractor is only one of several agreements to which this Aggregate Maximum Obligation applies. It therefore is understood by the parties that reimbursement to Contractor will be only a fraction of this Aggregate Maximum with the appropriate authorization.

**II. REIMBURSEMENT REQUIREMENTS**

The following requirements must be met in order for the Department of Behavioral Health (DBH) to consider reimbursing the Contractor for indigent care services:

1. Contractor shall be considered for reimbursement for indigent care services only when a patient whose inpatient stay originates under one or more of the following four (4) conditions:
  - a. Patient is transferred from Arrowhead Regional Medical Center by DBH
  - b. 5150 written by a Peace Officer (Law Enforcement)
  - c. 5150 written by DBH Community Crisis Services (CCRT, CWIC)
  - d. 5150 patient is transferred from a medical hospital emergency department or inpatient department, only if also meeting either condition b. or c. above.

Patients admitted under a voluntary status will be considered for reimbursement only when Medical Necessity is met and all administrative requirements of this contract are met.

For all of the above conditions, Contractor is required to send 5150 paperwork to the Quality Management Division. Contractor must attach a 24 hour notice for all San Bernardino County indigent clients being served at Contractor's facility for which Contractor is seeking reimbursement. Each 24 hour notice must have the corresponding 5150 attached. Contractor shall send paperwork to the Quality Management Division via fax at 909-873-4441.

All other claims for services not listed above will not be eligible for reimbursement under this contract except when under extenuating circumstances and approved by Quality Management.

2. In order for the Contractor to be reimbursed, the documentation in the patient's medical record must meet all of the medical necessity criteria specified in Section 1820.205 of Title 9 of the California Code of Regulations.
3. Whenever a patient whose inpatient stay the Contractor anticipates billing through the Indigent Care Services Program is admitted, the Contractor must notify the Point of Authorization (using the standard 24-hour Notification Form) within 24 hours of admission. The form should be faxed to the Point of Authorization at (909) 873-4441.
4. The patient is determined by the Contractor to be a resident of San Bernardino County. Residency will be determined by a preponderance of the evidence, taking into consideration the following factors prior to the current hospitalization.
  - a. Reasoned intent to reside or continue to reside in San Bernardino County prior to the current hospitalization. The following factors may be taken into account by DBH when determining whether reasoned intent exists:
    - i. History of having resided in San Bernardino County for at least three consecutive months;
    - ii. Documented offer of employment within San Bernardino County, which is valid at the time of admission to the hospital;
    - iii. Presence of a support system (relatives or friends) within San Bernardino County that is willing to provide continuing shelter to the patient.
  - b. Documented history of receiving mental health services within the last two years within San Bernardino County.
  - c. The existence of a physical dwelling, whether owned, rented or otherwise available, to which the patient can return after discharge from the hospital.
  - d. A patient's receipt of public benefits (i.e., AFDC, General Assistance) within San Bernardino County.
  - e. Probation or conditional release status that restricts the patient to a particular locale within San Bernardino County.
  - f. The patient is an LPS or probate conservatee pursuant to an order issued by a Court within the County of San Bernardino.
5. The following are additional factors for determining residency for minors:
  - a. Wards and dependents placed by the Juvenile Court are considered residents of the county of their current court jurisdiction.

- b. Special education pupils placed pursuant to an AB2726 (formerly AB3632) individualized Educational Plan (IEP) are considered residents of the county (and school district) in which their parents or conservator resides until they reach their 22<sup>nd</sup> birthdays, provided they remain in placement to a special education IEP.
  - c. Minors who are adopted through public agency adoptions remain the responsibility of the county making the adoptive placement.
- 6. All UB-92 forms requesting payment for inpatient psychiatric hospitalization through the Indigent Care Services Program must be correctly submitted within 45 days of the date of discharge.
- 7. If the patient has any other form of insurance that provides payment for inpatient psychiatric services, s/he is NOT eligible for coverage through the indigent care services program.
- 8. Pursuant to the provisions of Sections 4025, 5717 and 5718 of the Welfare & Institutions Code, and as further contained in the State Department of Mental Health Revenue Manual, Section I, Contractor shall collect revenues for the provision of the services described pursuant to Addendum I. Such revenues may include but are not limited to, fee for services, private contributions, grants or other funds. All revenues received by Contractor shall be reported in their annual Cost Report, and shall be used to offset gross cost.
- 9. Patient/client eligibility for reimbursement from Medi-Cal, Private Insurance, Medicare or other third party benefits, shall be determined by the Contractor. Contractor shall pursue payment from all potential sources in sequential order, with Medi-Cal as payer of last resort. Contractor is to attempt to collect first from Medicare (if site is Medicare certified), then insurance and then first party.
- 10. When an adult age 21 through 64 who is a Medi-Cal beneficiary is admitted to a free-standing hospital, that hospital must notify the Inpatient Authorization Unit within eight (8) hours of the admission. This notification should be by telephone call to the Point of Authorization telephone number: 909-873-4414. Additionally, adult Medi-Cal cases admitted to free-standing facilities will be considered for one (1) day of reimbursement with indigent funds only when transfer efforts are clearly noted in the chart and Medical Necessity is met.
- 11. All items in all attachments must be fully and correctly completed in order to determine eligibility for reimbursement under the indigent care services program.
- 12. Reimbursement Standards
  - a. Contractor shall take reasonable precaution to ensure that the coding of health care claims and billing for same are prepared and submitted

in an accurate and timely manner and are consistent with federal, state and county laws and regulations. This includes compliance with federal and state health care program regulations and procedures or instructions otherwise communicated by regulatory agencies including the Centers for Medicare and Medicaid Services or their agents.

- b. Contractor shall not submit false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.
- c. Contractor shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, Contractor shall use only correct billing codes that accurately describe the services provided.
- d. Contractor shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified.

**APPLICATION FOR REIMBURSEMENT OF TREATMENT  
TO MEDICALLY INDIGENT ADULT IN CONTRACT HOSPITAL**

Client Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Hospital \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

**1. CLIENT INFORMATION**

☐ Male  
☐ Female

\_\_\_\_\_  
Last Name First Name M.I.  
☐ Single ☐ Married ☐ Separated  
Age: \_\_\_\_\_ ☐ Widowed ☐ Divorced

Current Address:

\_\_\_\_\_  
Street City State How Long? \_\_\_\_\_

\_\_\_\_\_  
Apt. or Space # Zip Code Country Telephone

Previous Address:

\_\_\_\_\_  
Street City State How Long? \_\_\_\_\_

\_\_\_\_\_  
Apt. or Space # Zip Code Country Telephone

Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Approx. Salary \$ \_\_\_\_\_ per \_\_\_\_\_ Length of Time in Current Job: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Does this policy include psychiatric inpatient coverage? ☐ YES ☐ NO

**2. INFORMATION REGARDING SPOUSE**

\_\_\_\_\_  
Last Name First Name M.I. DOB SSN

**Address (write "SAME" if same.)**

Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Approx. Salary \$ \_\_\_\_\_ per \_\_\_\_\_ Length of Time in Current Job: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Does this policy include psychiatric inpatient coverage?

☐ YES☐ NO**3. RESIDENCY STATUS DETERMINED BY:**

a. Reasoned intent as demonstrated by:

- i. having resided in San Bernardino County for at least three consecutive months;
- ii. documented offer of employment within San Bernardino County;
- iii. presence of a support system within San Bernardino County.

b. Documented history of receiving mental health services in San Bernardino County within the last two years.

c. Existence of a physical dwelling within San Bernardino County to which patient can return.

d. Patient receives public benefits within San Bernardino County.

e. Patient on probation or conditional release status which restricts him/her to a particular locale within San Bernardino County.

f. Patient is an LPS or probate conservatee pursuant to an order issued by a Court within the County of San Bernardino.

**4.** Does the patient have any form of insurance other than that reported on Page 1 of this form which would provide payment for inpatient psychiatric services:

\_\_\_\_\_ YES; name of insurance carrier: \_\_\_\_\_

\_\_\_\_\_ NO

**5.** If the patient reports employment—or spouse's employment—in response to the questions on Page 1 of this form, CONTRACTOR must arrange for an evaluation of the patient's financial status by one of its financial interviewers.

**6.** Payment plan NOT arranged with patient for the following reason(s):

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The above is stated on information and belief and I declare under penalty of perjury under the laws of the State of California that I believe it to be true.

\_\_\_\_\_  
Patient Signature (required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hospital Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Hospital Representative

\_\_\_\_\_  
Title of Hospital Representative

**APPLICATION FOR REIMBURSEMENT OF TREATMENT  
TO MEDICALLY INDIGENT CHILD IN CONTRACT HOSPITAL**

Client Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Hospital \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Title \_\_\_\_\_ Phone \_\_\_\_\_

**1. CLIENT INFORMATION**

☐ Male  
☐ Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
☐ Single ☐ Married ☐ Separated  
 Age: \_\_\_\_\_ ☐ Widowed ☐ Divorced

Current Address:

\_\_\_\_\_ How Long? \_\_\_\_\_  
 Street City State

\_\_\_\_\_ Apt. or Space # Zip Code Country Telephone

Previous Address:

\_\_\_\_\_ How Long? \_\_\_\_\_  
 Street City State

\_\_\_\_\_ Apt. or Space # Zip Code Country Telephone

Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Approx. Salary \$ \_\_\_\_\_ per \_\_\_\_\_ Length of Time in Current Job: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Does this policy include psychiatric inpatient coverage? ☐ YES ☐ NO

**2. INFORMATION REGARDING MOTHER**

\_\_\_\_\_ Last Name First Name M.I. DOB SSN

\_\_\_\_\_ Address (write "SAME" if same.)

Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Approx. Salary \$ \_\_\_\_\_ per \_\_\_\_\_ Length of Time in Current Job: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Does this policy include psychiatric inpatient coverage? ☐ YES ☐ NO

**3. INFORMATION REGARDING FATHER**

\_\_\_\_\_

Last Name First Name M.I. DOB SSN

Address (write "SAME" if same.)

Current Employer: Job Title:

Approx. Salary \$ per Length of Time in Current Job:

Health Insurance Carrier: Plan Name:

Policy #:

Does this policy include psychiatric inpatient coverage? ☐ YES ☐ NO

**4. RESIDENCY STATUS DETERMINED BY:**

☐ Address of Parent or Guardian

☐ Other

**5. Does the patient have any form of insurance other than that reported on Page 1 of this form which would provide payment for inpatient psychiatric services:**

YES; name of insurance carrier:

NO

**6. Payment plan NOT arranged with patient for the following reason(s):**

The above is stated on information and belief and I declare under penalty of perjury under the laws of the State of California that I believe it to be true.

Patient ( Parent) Signature (required)

Date

Hospital Representative Signature

Date

Printed Name of Hospital Representative

Title of Hospital Representative

**FACILITY APPLICATION FOR INDIGENT CARE REIMBURSEMENT**

PATIENT DATA:

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Last Name	First Name	M.I.	DOB	SSN
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Admitting Diagnosis:

Axis I  
Axis II  
Axis III  
Axis IV  
Axis V

To be completed by attending psychiatrist:

Please check any of the following that apply:

- ☐ This patient suffers from a medical condition that would render him/her disabled from work for more than 30 days.
- ☐ This patient suffers from a medical condition that would render him/her disabled from work for more than one year.
- ☐ The mental disorder that led to this individual's admission is due to a pregnancy related or post-partum condition.

**The above is stated on information and belief and I declare under penalty of perjury under the laws of the State of California that I believe it to be true.**

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Attending Psychiatrist's Signature

## San Bernardino County Mental Health Plan (MHP) Grievance Procedure

### BENEFICIARY COMPLAINTS, APPEALS AND/OR GRIEVANCES

Title 9 of the California Code of Regulations requires that the Mental Health Plan (MHP) and its fee-for-service providers provide verbal and written information to Medi-Cal beneficiaries regarding the following:

- How to access specialty mental health services
- How to file a grievance about services
- How to file an appeal
- How to file for a State Fair Hearing

The MHP has developed a *Guide to Medi-Cal Mental Health Services*, a Grievance Process poster, a Grievance Form, an Appeal Form, and Request for Change of Provider Form. All of these beneficiary materials must be posted in prominent locations where Medi-Cal beneficiaries receive outpatient specialty mental health services, including the waiting rooms of providers' offices of service.

**Please note that all fee-for-service providers and contract agencies are required to give their beneficiaries copies of all current beneficiary information at intake and annually at the time their treatment plans are updated.**

Provided below is additional information about the grievance process.

#### **GRIEVANCES BY BENEFICIARIES** (Verbal and/or Written)

A grievance is an expression of dissatisfaction about any matter other than an action. Beneficiaries are encouraged to discuss issues and concerns regarding their mental health services directly with their provider(s). A grievance can be a verbal or a written statement of the beneficiary's concerns or problems. The beneficiary has the right to use the grievance process at any time.

Grievances, including those made by families, legal guardians, or conservators of beneficiaries, may be directed to the provider, the Access Unit and/or a completed Grievance Form may be sent to the DBH Access Unit or Patient's Rights Office. Grievance forms and pre-addressed envelopes to the Access Unit must be available at all providers' offices in locations where the beneficiary may obtain them without making a verbal request. If beneficiaries have questions regarding the grievance process, they may contact their providers, the Access Unit, or the Office of Patients' Rights. The Access Unit records the grievance in a log within one (1) working day of the date of the receipt of the grievance. The Access Unit sends an acknowledgement letter and resolution letter to the beneficiary as hereafter described. The Access Unit or MHP designee has sixty (60) calendar days to ensure a grievance is resolved. Fourteen (14) day extensions are allowed if the beneficiary requests or the MHP determines it is in the best interest of the beneficiary. Grievances are tracked by the Access Unit and sent to Quality Management after resolution.

#### **APPEALS BY BENEFICIARIES** (Verbal and/or Written)

Appeals may be filed when the beneficiary is dissatisfied after receipt of a Notice of Action, which:

1. **Denies or limits authorization of a requested service, including the type or level of service**
2. **Reduces, suspends, or terminates a previously authorized service**
3. **Denies, in whole or in part, payment for a service**
4. **Fails to provide services in a timely manner, as determined by the MHP**
5. **Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals, as hereafter described**

**San Bernardino County Mental Health Plan (MHP) Grievance Procedure****BENEFICIARY COMPLAINTS, APPEALS AND/OR GRIEVANCES****APPEAL PROCESS**

1. A beneficiary may verbally appeal to the Access Unit or complete an Appeal Form, which is to be forwarded to the Access Unit. If verbal, it must be followed up in writing within forty-five (45) days. The Access Unit sends an acknowledgement letter when an appeal is received. The verbal appeal establishes the earliest filing date.
2. The Access Unit records the appeal in a log within one (1) working day of the date the appeal is received and sends an acknowledgment letter of receipt to the beneficiary. The Access Unit maintains and tracks the appeals.
3. A written decision is to be issued by the Access Unit within forty-five (45) calendar days from the date of receipt of the form, and mailed to the beneficiary. Fourteen (14) calendar day extensions are allowed if the beneficiary requests or the MHP thinks it is in the best interest of the beneficiary. The Access Unit sends an acknowledgement letter and resolution letter to the beneficiary.
4. Expedited Appeals can be requested if the time for the standard resolution could seriously jeopardize the beneficiary's life, health or ability to function. The parties will be notified of the MPH decision no later than three (3) working days after the MHP has received the appeal.

**REQUEST FOR A STATE FAIR HEARING**

In addition, beneficiaries who have received a Notice of Action (NOA) and have completed the grievance and appeals process may request a State Fair Hearing. The beneficiary has ninety (90) days in which to request the hearing. The beneficiary may also be eligible to continue receiving services pending the outcome of the hearing, if the request is made within ten (10) days of receipt of the (NOA).

The Access Unit tries to ensure problems are resolved before the State Fair Hearing, but if necessary writes a position paper which is sent to the Medi-Cal Field Office with a copy sent to the beneficiary two (2) days before the hearing.

The "Fair Hearing Tracking Log" is maintained by the Access Unit to monitor the progress and resolution of each request for a Fair Hearing.

The Access Unit is responsible for coordination with the State Department of Social Service, State Department of Mental Health, providers and Consumers regarding the Fair Hearing process. The Access Unit also oversees compliance with the decision of the hearing.

The Access Unit sends a MHP representative to the hearing with the Administrative Law Judge, and/or the beneficiary, and/or authorized representative.

Hearings are requested through calling or writing to:

State Hearing Division California Department of Social Services

PO Box 944243

Sacramento, CA 94244-2430

Telephone: (800) 952-5253

TDD: (800) 952- 8349

## San Bernardino County Mental Health Plan (MHP) Grievance Procedure

### BENEFICIARY COMPLAINTS, APPEALS AND/OR GRIEVANCES

#### ADDITIONAL POINTS

At any time during the grievance, appeal, or State Fair Hearing processes, the beneficiary may authorize a person to act on his or her behalf, to use the grievance/ resolution process on his or her behalf, or to assist him or her with the process.

Filing a grievance will not restrict or compromise the beneficiary's access to mental health services.

At any time during the grievance process, the beneficiary may contact the Access Unit at (888) 743-1478 or the Patient's Rights' Office at (800) 440-2391 for assistance.

#### GRIEVANCES REGARDING PROVIDERS AND SERVICES

Grievances by beneficiaries about providers or mental health services may be made to the Access Unit or to the Patients' Rights Office. Grievances will be reviewed and investigated by the appropriate office within the Department of Behavioral Health, and the issues contained therein will be reviewed by Quality Management. Providers cited by the beneficiary or otherwise involved in the grievance process will be notified of the final disposition of that grievance.

Concerns of the Department of Behavioral Health regarding a provider's possible unprofessional, unethical, incompetent, or breach-of-contract behavior will be investigated by the Patients' Rights Office or other department, by appropriate state licensing authorities, or by Quality Management. In extreme cases, in which beneficiary safety is at risk, the Director may suspend the provider's credentialed status while an investigation is pending.

Providers will prominently display and make available printed materials, which announce and explain the grievance, appeal and State Fair Hearing processes without the beneficiary having to make a verbal or written request for these materials. The Department of Behavioral Health has the *Guide to Medi-Cal Mental Health Services* and poster in the two (2) County threshold languages. ***Any grievance initiated with a provider by a beneficiary should be immediately forwarded from the provider to the Access Unit.***

#### PROVIDER PROBLEM RESOLUTION AND APPEAL PROCESS

##### GRIEVANCES (verbal)

Provider grievances regarding the system-of-care structure and procedures may be directed verbally to the Access Unit, who may be able to resolve or explain the issue.

When a provider grievance concerns a denied or modified request for payment authorization, or the processing or payment of a provider's claim, the provider has a right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun.

##### APPEALS (written)

In response to a denied or modified request for payment authorization, or a dispute concerning the processing or payment of a claim, a provider may make use of the written Provider Appeal Process. The written appeal must be sent to the Access Unit Supervisor within ninety (90) calendar days of the date of receipt of the non-approval of payment or within ninety (90) calendar days of the MHP's failure to act on a request.

The Program Manager or designee will communicate a response to the provider within sixty (60) calendar days of receipt of the appeal. It will include a statement of the reasons for the decision that addresses each issue raised by the provider and any action required by the provider to implement the decision. If applicable, the provider shall submit a revised request for MHP payment authorization within thirty (30) calendar days from receipt of the MHP's decision to approve the payment authorization request. If the Program Manager or designee does not respond to the appeal within sixty (60) calendar days of receiving it, the appeal shall be considered denied.

## BUSINESS ASSOCIATE AGREEMENT

Except as otherwise provided in this Agreement, Redlands Community Hospital, hereinafter referred to as BUSINESS ASSOCIATE, may use, access or disclose Protected Health Information to perform functions, activities or services for or on behalf of the COUNTY OF SAN BERNARDINO, hereinafter referred to as the COVERED ENTITY, as specified in this Agreement and the attached **CONTRACT**, provided such use, access or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 United States Code (USC) 1320d et seq., and its implementing regulations, including but not limited to, 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164, hereinafter referred to as the Privacy and Security Rules and patient confidentiality regulations, including but not limited to, California Civil Code 56 – 56.16, 56.20, 56.36, and Health and Safety Codes 1280.1, 1280.3, 1280.15, 130200 Title 42 of the Code of Federal Regulations Part 2 and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (the "HITECH Act") and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates. Business Associate recognizes and agrees it is obligated by law to meet the applicable provisions of the HITECH Act.

### I. Definitions.

- a. "Breach" means the acquisition, access, use or disclosure of Protected Health Information (PHI) in a manner not permitted under HIPAA (45 CFR Part 164, Subpart E), CA and/or Civil Code 56.36 which compromises the security or privacy of the Protected Health Information. For the purposes of HITECH, a breach shall not include:
  1. Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of Covered Entity or the Business Associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Rule; or
  2. Any inadvertent disclosure by a person who is authorized to access PHI at Covered Entity or Business Associate to another person authorized to access Protected Health Information at Covered Entity or Business Associate, respectively, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Rule; or
  3. A disclosure of PHI where Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
- b. "Business Associate" means with respect to a Covered Entity, a person who:
  1. On behalf of such Covered Entity, but other than in the capacity of a member of the workforce of such Covered Entity performs or assists in the performance of :
    - (a) a function or activity involving the use or disclosure of Personally Identifiable Health Information, including claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
    - (b) any other function or activity regulated by the HIPAA Privacy or HIPAA Security Regulations; or

2. Provides, other than in the capacity of a member of the workforce of such Covered Entity, legal, actuarial, accounting, consulting, data Aggregation, management, administrative, accreditation or financial services to or for such Covered Entity where the provision of the service involves the disclosure of Personally Identifiable Health Information from such Covered Entity to the person.
- c. "Patient/Client" means Covered Entity funded person who is the patient or client of the Business Associate.
  - d. "Covered Entity" means a health plan, a health care clearinghouse or a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA Privacy and Security Regulations.
  - e. "Data Aggregation" means, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a Covered Entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another Covered Entity, to permit data analyses that relate to the health care operations of the respective Covered Entities.
  - f. "Discovered" means a breach shall be treated as discovered by Covered Entity or Business Associate as the first day on which such breach is known to such Covered Entity or Business Associate, respectively, (including any person, other than the individual committing the breach, that is an employee, officer or other agent of such entity or associate, respectively) or should reasonably have been known to such Covered Entity or Business Associate (or person) to have occurred.
  - g. "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media as defined in the HIPAA Security Regulations.
  - h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
  - i. "HIPAA Privacy Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the privacy of Protected Health Information, including, but not limited to, 45 CFR Part 160 and 45 CFR Part 164, Subpart A and Subpart E.
  - j. "HIPAA Security Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the security of Electronic Protected Health Information, including, but not limited to, 45 CFR Part 160 and 45 CFR Part 164, Subpart A and Subpart C.
  - k. "HITECH Act" means the privacy, security and security Breach notification provisions applicable to Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), which is Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and any regulations promulgated thereunder.
  - l. "Personally Identifiable Health Information" means information that is a subset of health information, including demographic information collected from an individual, and;
    1. is created or received by a health care provider, health plan, employer or health care clearinghouse; and

2. relates to the past, present or future physical or mental health 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; and
    - (a) that identifies the individual; or
    - (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
  - m. "Protected Health Information" or "PHI" means Personally Identifiable Health Information transmitted or maintained in any form or medium that (i) is received by Business Associate from Covered Entity, (ii) Business Associate creates for its own purposes from Personally Identifiable Health Information that Business Associate received from Covered Entity, or (iii) is created, received, transmitted or maintained by Business Associate on behalf of Covered Entity. Protected Health Information excludes Personally Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. Section 1232(g), records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv), and employment records held by the Covered Entity in its role as employer.
  - n. "Secured PHI" means PHI that was rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technologies or methodologies specified under Section 13402 (h)(2) of the HITECH Act under ARRA.
  - o. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.
  - p. Any terms capitalized, but not otherwise defined, in this Agreement shall have the same meaning as those terms have under HIPAA, the HIPAA Privacy Rule, the HIPAA Security Rule and the HITECH Act.
- I. Obligations and Activities of Business Associate.**
- a. **Permitted Uses.** Business Associate shall not use, access or further disclose Protected Health Information other than as permitted or required by this Agreement and as specified in the attached **CONTRACT** or as required by law. Further, Business Associate shall not use Protected Health Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act. Business Associate shall disclose to its employees, subcontractors, agents, or other third parties, and request from Covered Entity, only the minimum Protected Health Information necessary to perform or fulfill a specific function required or permitted hereunder.
  - b. **Prohibited Uses and Disclosures.** Business Associate shall not use or disclose Protected Health Information for fundraising or marketing purposes. Business Associate shall not disclose Protected Health Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the Protected Health Information solely relates; 42 U.S.C. Section 17935(a) and 45 C.F.R. section 164.522(a)(1)(i)(A). Business Associate shall not directly or indirectly receive remuneration in exchange for Protected Health Information, except with the prior written consent of Covered Entity and as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to this Agreement.

- c. **Appropriate Safeguards.** Business Associate shall implement the following administrative, physical, and technical safeguards in accordance with the Security Rule under 45 C.F.R., Sections 164.308, 164.310, 164.312 and 164.316:
1. Implement policies and procedures to prevent, detect, contain and correct security violations; identify the security official who is responsible for the development and implementation of the policies and procedures required by this subpart for the entity; implement a security awareness and training program for all members of its workforce; implement policies and procedures to prevent those workforce members who do not have access from obtaining access to electronic PHI; implement policy and procedures to address security incidents; establish policies and procedures for responding to an emergency or other occurrence that damages systems that contain electronic PHI; and perform a periodic technical and nontechnical evaluation in response to environmental or operational changes affecting the security of electronic PHI that establishes the extent to which an entity's security policies and procedures meet the requirements of this subpart.
  2. Implement policies and procedures to limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed; implement policies and procedures that specify the proper functions to be performed, and the physical attributes of the surroundings of a specific workstation or class of workstations that can access electronic PHI; implement physical safeguards for all workstations that access electronic PHI; restrict access to authorized users; implement policies and procedures that govern the receipt and removal of hardware and electronic media that contain electronic PHI into and out of a facility and the movement of these items within the facility.
  3. Implement technical policies and procedures for electronic information systems that maintain electronic PHI to allow access only to those persons or software programs that have been granted access rights as specified in 45 C.F.R., Section 164.208; implement hardware, software and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic PHI; implement policies and procedures to protect electronic PHI from improper alteration, destruction, unauthorized access or loss of integrity or availability.
- d. **Mitigation.** Business Associate shall have procedures in place to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use, access or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- e. **Reporting of Improper Access, Use or Disclosure or Breach.** Business Associate shall report to Covered Entity's Office of Compliance any unauthorized use, access or disclosure of unsecured Protected Health Information or any other security incident with respect to Protected Health Information no later than two (2) business days upon the discovery of potential breach. Additionally, effective February 17, 2010, the Business Associate shall report to the Covered Entity's Office of Compliance any breach consistent with the regulations promulgated under HITECH by the United States Department of Health and Human Services, 45 CFR Part 164, Subpart D, within two (2) business days of discovery of the potential breach. Upon discovery of the potential breach, the Business Associate shall complete the following actions:
1. Provide Covered Entity's Office of Compliance with the following information to include but not limited to:

- (a) Date the potential breach occurred;
  - (b) Date the potential breach was discovered;
  - (c) Number of staff, employees, subcontractors, agents or other third parties and the titles of each person allegedly involved;
  - (d) Number of potentially affected patients/clients; and
  - (e) Description of how the potential breach allegedly occurred.
2. Conduct and document a risk assessment by investigating without reasonable delay and in no case later than twenty (20) calendar days of discovery of the potential breach to determine the following:
    - (a) Whether there has been an impermissible use, acquisition, access or disclosure of PHI under the Privacy Rule;
    - (b) Whether an impermissible use or disclosure compromises the security or privacy of the PHI by posing a significant risk of financial, reputational or other harm to the patient/client; and
    - (c) Whether the incident falls under one of the breach exceptions.
  3. Provide completed risk assessment and investigation documentation to Covered Entity's Office of Compliance within twenty-five (25) calendar days of discovery of the potential breach with decision whether a breach has occurred.:
    - (a) If a breach has not occurred, notification to patient/client(s) is not required.
    - (b) If a breach has occurred, notification to the patient/client(s) is required, and Business Associate must provide and send notification to the affected patient and make available to the Covered Entity.
  4. Make available to Covered Entity and governing State and Federal agencies in a time and manner designated by Covered Entity or governing State and Federal agencies, any policies, procedures, internal practices and records relating to a potential breach for the purposes of audit or should the Covered Entity reserve the right to conduct its own investigation and analysis.
- f. **Permitted Disclosures.** If Business Associate discloses Protected Health Information to a third party, including any agent or subcontractor, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Health Information will be held confidential as provided pursuant to this Agreement and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) an agreement from such third party to immediately notify Business Associate of any breach of confidentiality of the Protected Health Information, to the extent it has obtained knowledge of such breach [42 U.S.C. Section 17932; 45 C.F.R. Sections 164.504(e)].
  - g. **Access to Protected Health Information.** Business Associate shall provide access to Protected Health Information in a Designated Record Set to Covered Entity or to an Individual, at the request or direction of Covered Entity and in the time and manner designated by the Covered Entity, as required by of 45 CFR 164.524.
  - h. **Amendment of Protected Health Information.** If Business Associate maintains a Designated Record Set on behalf of the Covered Entity, Business Associate shall make any amendment(s) to Protected Health Information in a Designated Record Set that the

Covered Entity directs or agrees to, pursuant to 45 CFR 164.526, in the time and manner designated by the Covered Entity.

- i. **Access to Records.** Business Associate shall make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use, access and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, and/or to the Secretary for the U.S. Department of Health and Human Services, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules and patient confidentiality regulations.
- j. **Audit and Monitor.** Covered Entity reserves the right to audit and monitor all records, policies, procedures and other pertinent items related to the use, access and disclosure of Protected Health Information of the Business Associate as requested to ensure Business Associate is in compliance with this Agreement. Covered Entity has the right to monitor Business Associate in the delivery of services provided under this Agreement. Business Associate shall give full cooperation in any auditing or monitoring conducted.
- k. **Accounting for Disclosures.** Business Associate shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information. Further, Business Associate shall provide to Covered Entity or an Individual, in the time and manner designated by the Covered Entity, information collected in accordance with provision (i), above, to permit Covered Entity to respond to a request by the Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528 and the HITECH Act.
- l. **Destruction of Protected Health Information.** Upon termination of this Agreement, Business Associate shall return all Protected Health Information required to be retained and return or destroy all other Protected Health Information received from the Covered Entity, or created or received by the Business Associate or its subcontractors, employees or agents on behalf of the Covered Entity. In the event the Business Associate determines that returning the Protected Health Information is not feasible, the Business Associate shall provide the Covered Entity with written notification of the conditions that make return not feasible. Business Associate further agrees to extend any and all protections, limitations, and restrictions contained in this Agreement, to any Protected Health Information retained by Business Associate or its subcontractors, employees or agents after the termination of this Agreement, and to limit any further use, access or disclosures to the purposes that make the return or destruction of the Protected Health Information infeasible.
- m. **Breach Pattern or Practice by Covered Entity.** Pursuant to 42 U.S.C. Section 17934(b), if the Business Associate knows of a pattern of activity or practice of the Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under this Agreement, the Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Business Associate must terminate the Agreement if feasible, or if termination is not feasible, report the problem to the Secretary of DHHS.
- n. **Costs Associated to Breach.** Business Associate shall be responsible for reasonable costs associated with a breach. Costs shall be based upon the required notification type as deemed appropriate and necessary by the Covered Entity and shall not be reimbursable under the contract at any time. Covered Entity shall determine the method

to invoice the Business Associate for said costs. Costs shall incur at the current rates and may include, but are not limited to the following:

1. Postage;
2. Alternative means of notice;
3. Media notification; and
4. Credit monitoring services.

**III. Specific Use and Disclosure Provisions.**

- a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law.
- c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation service to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).
- d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1).

**IV. Obligations of Covered Entity.**

- a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use, access or disclosure of Protected Health Information.
- b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an individual to use, access or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use, access or disclosure of Protected Health Information.
- c. Covered Entity shall notify Business Associate of any restriction to the use, access or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use, access or disclosure of Protected Health Information.
- d. Covered Entity shall complete the following in the event that the Covered Entity has determined that Business Associate has a breach:
  1. Determine appropriate method of notification to the patient/client(s) regarding a breach as outlined under Section 13402(e) of the HITECH Act;
  2. Send notification to the patient/client(s) without unreasonable delay but in no case later than sixty (60) days of discovery of the breach with at least the minimal required elements as follows:
    - (a) Brief description of what happened, including the date of the breach and the date of discovery;

- (b) Description of the types of unsecured PHI involved in the breach (such as name, date of birth, home address, Social Security number, medical insurance, etc.);
  - (c) Steps patient/client(s) should take to protect themselves from potential harm resulting from the breach;
  - (d) Brief description of what is being done to investigate the breach, to mitigate harm to patient/client(s) and to protect against any further breaches; and
  - (e) Contact procedures for patient/client(s) to ask questions or learn additional information, which must include a toll-free telephone number, an e-mail address, Web site or postal address.
3. Determine if notice is required to Secretary of the U.S. Department of Health and Human Services.
  4. Submit breach information to the Secretary of the U.S. Department of Health and Human Services within the required timeframe, in accordance with 164.408(b).

**V. General Provisions.**

- a. **Remedies.** Business Associate agrees that Covered Entity shall be entitled to seek immediate injunctive relief as well as to exercise all other rights and remedies which Covered Entity may have at law or in equity in the event of an unauthorized use, access or disclosure of Protected Health Information by Business Associate or any agent or subcontractor of Business Associate that received Protected Health Information from Business Associate.
- b. **Ownership.** The Protected Health Information shall be and remain the property of the Covered Entity. Business Associate agrees that it acquires no title or rights to the Protected Health Information.
- c. **Regulatory References.** A reference in this Agreement to a section in the Privacy and Security Rules and patient confidentiality regulations means the section as in effect or as amended.
- d. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act and patient confidentiality regulations.
- e. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules and patient confidentiality regulations.
- f. **Indemnification.** Business Associate agrees to indemnify, defend and hold harmless Covered Entity and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, injuries, costs and expenses (including costs for reasonable attorney fees) that are caused by or result from the acts or omissions of Business Associate, its officers, employees, agents and subcontractors, with respect to the use, access or disclosure of Covered Entity's PHI.

**ATTESTATION REGARDING INELIGIBLE / EXCLUDED PERSONS****Contractor shall:**

To the extent consistent with the provisions of this Agreement, comply with regulations found in Title 42 Code of Federal Regulations (CFR), Parts 1001 and 1002, et al regarding exclusion from participation in federal and state funded programs, which provide in pertinent part:

1. Contractor certifies to the following:
  - a. it is not presently excluded from participation in federal and state funded health care programs,
  - b. there is not an investigation currently being conducted, presently pending or recently concluded by a federal or state agency which is likely to result in exclusion from any federal or state funded health care program, and/or
  - c. unlikely to be found by a federal and state agency to be ineligible to provide goods or services.
2. As the official responsible for the administration of Contractor, the signatory certifies the following:
  - a. all of its officers, employees, agents, sub-contractors and/or persons having five percent (5%) or more of direct or indirect ownership or control interest of the Contractor are not presently excluded from participation in any federal or state funded health care programs,
  - b. there is not an investigation currently being conducted, presently pending or recently concluded by a federal or state agency of any such officers, employees, agents and/or sub-contractors which is likely to result in an exclusion from any federal and state funded health care program, and/or
  - c. its officers, employees, agents and/or sub-contractors are otherwise unlikely to be found by a federal or state agency to be ineligible to provide goods or services.
3. Contractor certifies it has reviewed, at minimum on an annual basis, the following lists in determining the organization nor its officers, employees, agents, sub-contractors and/or persons having five percent (5%) or more of direct or indirect ownership or control interest of the Contractor are not presently excluded from participation in any federal or state funded health care programs:
  - a. OIG's List of Excluded Individuals/Entities (LEIE).
  - b. United States General Service Administration's Excluded Parties List System (EPLS).
  - c. California Department of Health Care Services Suspended and Ineligible Provider List, if receives Medi-Cal reimbursement.
4. Contractor certifies that it shall notify DBH within ten (10) business days in writing of:
  - a. Any event, including an investigation, that would require Contractor or any of its officers, employees, agents and/or sub-contractors exclusion or suspension under federal or state funded health care programs, or
  - b. Any suspension or exclusionary action taken by an agency of the federal or state government against Contractor, or one or more of its officers, employees, agents and/or sub-contractors, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federal or state funded healthcare program payment may be made.

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**Printed name of authorized official**

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**Signature of authorized official**

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**Date**

This is to notify you of the your obligations relating to the American Recovery and Reinvestment Act of 2009, pursuant to the Contract \_\_\_-\_\_\_ with San Bernardino County.

**AMERICAN RECOVERY AND REINVESTMENT ACT FUNDING (ARRA)**

**Use of ARRA Funds and Requirements**

This Contract may be funded in whole or in part with funds provided by the American Recovery and Reinvestment Act of 2009 ("ARRA"), signed into law on February 17, 2009. Section 1605 of ARRA prohibits the use of recovery funds for a project for the construction, alteration, maintenance or repair of a public building or public work (both as defined in 2 CFR 176.140) unless all of the iron, steel and manufactured goods (as defined in 2 CFR 176.140) used in the project are produced in the United States. A waiver is available under three limited circumstances: (i) Iron, steel or relevant manufactured goods are not produced in the United States in sufficient and reasonable quantities and of a satisfactory quality; (ii) Inclusion of iron, steel or manufactured goods produced in the United States will increase the cost of the overall project by more than 25 percent; or (iii) Applying the domestic preference would be inconsistent with the public interest. This is referred to as the "Buy American" requirement. Request for a waiver must be made to the County for an appropriate determination.

Section 1606 of ARRA requires that laborers and mechanics employed by contractors and subcontractors on projects funded directly by or assisted in whole or in part by and through the Federal Government pursuant to ARRA shall be paid wages at rates not less than those prevailing on projects of a character similar in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act (40 U.S.C. 31). This is referred to as the "wage rate" requirement.

The above described provisions constitute notice under ARRA of the Buy American and wage rate requirements. Contractor must contact the County contact if it has any questions regarding the applicability or implementation of the ARRA Buy American and wage rate requirements. Contractor will also be required to provide detailed information regarding compliance with the Buy American requirements, expenditure of funds and wages paid to employees so that the County may fulfill any reporting requirements it has under ARRA. The information may be required as frequently as monthly or quarterly. Contractor agrees to fully cooperate in providing information or documents as requested by the County pursuant to this provision. Failure to do so will be deemed a default and may result in the withholding of payments and termination of this Contract.

Contractor may also be required to register in the Central Contractor Registration (CCR) database at <http://www.ccr.gov> and may be required to have its subcontractors also register in the same database. Contractor must contact the County with any questions regarding registration requirements.

**Schedule of Expenditure of Federal Awards**

In addition to the requirements described in "Use of ARRA Funds and Requirements," proper accounting and reporting of ARRA expenditures in single audits is required. Contractor agrees to separately identify the expenditures for each grant award funded under ARRA on the Schedule of Expenditures of Federal Awards (SEFA) and the Data Collection Form (SF-SAC required by the Office of Management and Budget Circular A-133, "Audits of States, Local

## Attachment IX

Governments, and Nonprofit Organizations.” This identification on the SEFA and SF-SAC shall include the Federal award number, the Catalog of Federal Domestic Assistance (CFDA) number, and amount such that separate accountability and disclosure is provided for ARRA funds by Federal award number consistent with the recipient reports required by ARRA Section 1512 (c).

In addition, Contractor agrees to separately identify to each subcontractor and document at the time of sub-contract and at the time of disbursement of funds, the Federal award number, any special CFDA number assigned for ARRA purposes, and amount of ARRA funds.

Contractor may be required to provide detailed information regarding expenditures so that the County may fulfill any reporting requirements under ARRA described in this section. The information may be required as frequently as monthly or quarterly. Contractor agrees to fully cooperate in providing information or documents as requested by the County pursuant to this provision. Failure to do so will be deemed a default and may result in the withholding of payments and termination of this Contract.

### Whistleblower Protection

Contractor agrees that both it and its subcontractors shall comply with Section 1553 of the ARRA, which prohibits all non-Federal contractors, including the State, and all contractors of the State, from discharging, demoting or otherwise discriminating against an employee for disclosures by the employee that the employee reasonably believes are evidence of: (1) gross mismanagement of a contract relating to ARRA funds; (2) a gross waste of ARRA funds; (3) a substantial and specific danger to public health or safety related to the implementation or use of ARRA funds; or (4) a violation of law, rule, or regulation related to an agency contract (including the competition for or negotiation of a contract) awarded or issued relating to ARRA funds.

*Contractor agrees that it and its subcontractors shall post notice of the rights and remedies available to employees under Section 1553 of Division A, Title XV of the ARRA.*

I do hereby acknowledge receipt of the American Recovery and Reinvestment Act (ARRA) Funding requirements that became effective August 12, 2009, and understand and agree to the contractual obligations stipulated herein for contracts with the County of San Bernardino.

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Printed Name

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Signature

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Title

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Company or Organization

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Contract Number(s)

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Date

Contract No. \_\_\_\_\_

MM/DD/YYYY to MM/DD/YYYY

[illegible]

**REPORT OF ENVIRONMENTALLY PREFERABLE GOODS AND SERVICES**  
**County of San Bernardino**

<b>EXAMPLES OF GREEN ATTRIBUTES</b>	<b>EXAMPLES OF CERTIFICATION AND/OR ACCREDITATION</b>
Biobased Biodegradable Carcinogen-free Chlorofluorocarbon (CFC)-free Compostable Energy efficiency Lead-free Less hazardous Low toxicity Mercury-free Persistent bioaccumulative toxin (PBT)-free Rapidly renewable Rechargeable Recyclable Recycled content Reduced greenhouse gas emissions Reduced packaging Refill/refillable Remanufactured/refurbished Renewable materials Responsible forestry Upgradeable Water efficiency	Certified Approved Product (AP) Non-Toxic Ecologo Certified Energy Star Electronic Product Environmental Assessment Tool (EPEAT) program Forest Stewardship Council Certified Green Seal Certified Greenguard Certified Scientific Certification Systems (SCS)