

SECOND AMENDMENT TO THE ORGANIZATIONAL PROVIDER AGREEMENT BETWEEN THE COUNTY OF VENTURA AND GOLDEN VENTURA CRT, LLC

This "Second Amendment" to the Agreement dated July 1, 2023, for Medi-Cal Specialty Mental Health Services is made and entered into by and between the **COUNTY OF VENTURA**, acting through its Behavioral Health Department (VCBH), a primary service provider, hereinafter referred to as "COUNTY", and **GOLDEN VENTURA CRT, LLC.**, hereinafter referred to as "CONTRACTOR".

NOW, THEREFORE, the parties hereby agree that the Agreement, is amended effective July 1, 2024 as follows:

- I. TERM: The term of this Agreement is extended through June 30, 2025, subject to budgetary approval by the Ventura County Board of Supervisors for FY 2024-25.
- II. The terms "member/members" shall be used throughout the agreement in place of "client/clients" "beneficiary/beneficiaries".
- III. Section 3 (PAYMENT) of the Agreement is revised to read as follows:
 3. **PAYMENT.** The maximum contract amount shall not exceed **\$2,370,000.** CONTRACTOR shall be paid in accordance with Exhibit "B" (PAYMENT TERMS).
- IV. Section 8 (CONFLICT OF INTEREST) of the Agreement is revised to read as follows:
 8. **CONFLICT OF INTEREST.** CONTRACTOR and CONTRACTOR's employees shall have no interest, and shall not acquire any interest, direct or indirect, which will conflict in any manner or degree with the performance of services required under this Agreement. CONTRACTOR acknowledges and agrees to comply with all applicable State and Federal laws and regulations governing conflicts of interest, including, but not limited to, the Political Reform Act, California Public Contract Code section 10365.5, California Government Code section 1090, 42 C.F.R. Section 438.58, and the prohibitions described in Social Security Act section 1902(a)(4)(C), and applicable to contracting officers, employees, or independent contractors.
- V. Section 9 (LAWS AND REGULATIONS), subsection B (Applicable Federal Law) and subsection D (Applicable California Law) of the Agreement is revised to read as follows:
 - B. Applicable Federal Law. CONTRACTOR shall comply with all applicable federal waivers, laws, regulations, and published guidelines (including without limitation all applicable subregulatory guidance, contract provisions, policy letters, procedures, rules, ordinances, directives, manuals, information notices, and any amendments or changes thereto) to the extent that these authorities contain requirements applicable to CONTRACTOR's performance under this Agreement. These authorities may include, but are not necessarily limited to the following:

- Title 2, Code of Federal Regulations (CFR) Part 200, Subpart F, Appendix II
- Applicable provision of Title 42 CFR
- Title 42 CFR Part 431, Subpart F
- Title 42 CFR Part 433, Subpart D
- Title 42 CFR Part 434
- Title 42 CFR Part 438
- Title 45 CFR Part 75, Subpart D
- Title 45 CFR Part 95, Subpart F
- Title 45 CFR Section 92.1
- Title 45 CFR Section 455
- Applicable Medi-Cal/Medicaid and Medicare laws, requirements, and rules
- Title VI of the Civil Rights Act of 1964
- Title IX of the Education Amendments of 1972
- Age Discrimination Act of 1975
- Rehabilitation Act of 1973
- Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act
- Health Insurance Portability and Accountability Act (HIPAA)
- Deficit Reduction Act of 2005
- Balanced Budget Act of 1997
- Copeland Anti-Kickback Act (18 USC § 874, 40 USC § 3145) and implementing regulations at 29 CFR Part 3, as may be amended.
- Davis Bacon Act, as amended (40 USC 3141 et seq.), and implementing regulations at 29 CFR Parts 1, 3, and 5, as may be amended.
- Contract Work Hours and Safety Standards Act (40 USC § 3701 et seq.) and implementing regulations at 29 CFR Part 5, as may be amended.
- Federal laws that pertain to member rights

D. Applicable California Law. CONTRACTOR shall comply with all California laws, regulations, state plan, and published guidelines (including without limitation all applicable subregulatory guidance, contract provisions, policy letters, procedures, rules, ordinances, directives, manuals, Mental Health and Substance Use Disorder Services (MHSUDS) information notices and Behavioral Health information notices (BHIN) (information notices), and any amendments or changes thereto) to the extent that these

authorities contain requirements applicable to CONTRACTOR's performance under this Agreement. These authorities may include, but are not necessarily limited to the following:

- California's Confidentiality of Medical Information Act (CMI), Civil Code Sections 56 – 56.37
- Applicable provisions of the California Welfare and Institutions Code, including but not limited to:
- Division 5
- Sections 14059.5 and 14184.402
- Sections 14680 – 14685.1
- Sections 14700 – 14727
- Chapter 7 of Part 3 of Division 9
- Applicable provisions of the California Health and Safety Code
- Applicable provisions of the California Business & Professions Code
- Title 9 of the California Code of Regulations, including but not limited to:
- Section 1810.100 et seq. (Medi-Cal Specialty Mental Health Services (SMHS)) except as otherwise superseded by applicable DHCS BHINs
- Title 22 of the California Code of Regulations, including but not limited to:
- Sections 50951, 50593, 51014.1, and 51.14.2
- California Department of Health Care Services (DHCS) behavioral health information notices
- Applicable provisions of DHCS Cost Reporting Data Collection Manual
- Applicable DHCS Health Care Finance Administration requirements

VI. Section 12 (INSURANCE PROVISIONS), of the Agreement is revised to read as follows:

12. INSURANCE PROVISIONS.

- A. CONTRACTOR, at its sole cost and expense, shall obtain and maintain in full force during the term of this Agreement the following types of insurance and list COUNTY's primary address, 800 South Victoria Avenue, Ventura, CA 93009 on all insurance documents.
- B. All insurance required will be primary coverage as respects COUNTY and any insurance or self-insurance maintained by COUNTY will be excess of CONTRACTOR's insurance coverage and will not contribute to it.
 - 1) General Liability "occurrence" coverage in the minimum amount of \$1,000,000 combined single limit (CSL) bodily injury and property damage

each occurrence and \$2,000,000 aggregate, including personal injury, broad form property damage, civil rights violations, products/completed operations broad form blanket contractual legal liability.

- 2) Commercial Automobile Liability coverage in the minimum amount of \$1,000,000 CSL bodily injury and property damage, including owned, non-owned and hired automobiles. Also to include Uninsured/Underinsured Motorists coverage in the minimum amount of \$100,000 when there are owned vehicles.
 - 3) Worker's Compensation coverage, in full compliance with California statutory requirements, for all employees of CONTRACTOR and Employer's Liability in the minimum amount of \$1,000,000.
 - 4) Professional Liability (Medical Malpractice) coverage in the minimum amount of \$1,000,000 each occurrence and \$2,000,000 aggregate.
 - 5) Cyber Liability coverage in the minimum amount of \$1,000,000 per Occurrence and \$2,000,000 annual aggregate.
 - 6) CONTRACTOR shall also obtain and thereafter maintain insurance for the actual cash value of personal property including, but not limited to, furniture, fixtures, supplies, or materials supplied by COUNTY or purchased with funds provided by COUNTY against hazards of fire, burglary, vandalism, and malicious mischief. If funding has not been provided for the purchase of personal property as described herein, this subparagraph shall not apply.
- B. All insurance required will be primary coverage as respects COUNTY and any insurance or self-insurance maintained by COUNTY will be excess of CONTRACTOR's insurance coverage and will not contribute to it.
- C. COUNTY is to be notified immediately if any aggregate insurance limit is exceeded. Additional coverage must be purchased to meet requirements.
- D. The County of Ventura, Ventura County Behavioral Health Department, and any applicable Special Districts are to be named as Additional Insured as respects to work done by CONTRACTOR under the terms of this Agreement on all policies required (except Worker's Compensation and Professional Liability). As part of the insurance verification process, CONTRACTOR will submit the Additionally Insured Endorsement to COUNTY as a separate document.
- E. CONTRACTOR agrees to waive all rights of subrogation against COUNTY, its boards, agencies, departments, any applicable special districts, officers, employees, agents, and volunteers for losses arising from work performed by CONTRACTOR under the terms of this Agreement. As part of the insurance verification process,

CONTRACTOR will submit proof of the waiver of subrogation to COUNTY as a separate document.

- F. Policies will not be canceled, non-renewed or reduced in scope of coverage until after thirty (30) days written notice from either the carrier or CONTRACTOR has given notice to the County of Ventura, Risk Management Division and VCBH.
- G. CONTRACTOR agrees to provide COUNTY with the following insurance documents on or before the effective date of this Agreement:
 - 1) Certificates of Insurance for all required coverage.
 - 2) A separate Additional Insured endorsement for General Liability Insurance.
 - 3) A separate Waiver of subrogation endorsements (a.k.a., "Waiver of Transfer of Rights Recovery Against Others" and "Waiver of Our Right to Recover from Others") for Workers Compensation.

Failure to provide these documents may be grounds for immediate termination or suspension of this Agreement.

- H. It is the responsibility of CONTRACTOR to confirm that all terms and conditions of the Insurance Provisions are complied with by any and all subcontractors that CONTRACTOR may use for the completion of this Agreement.
- I. Insurance coverage in the minimum amounts set forth herein shall not be construed to relieve CONTRACTOR for liability in excess of such coverage, nor shall it preclude COUNTY from taking such other actions as are available to it under any other provisions of this Agreement or otherwise under the law.
- J. CLAIMS MADE INSURANCE. If the Professional Liability coverage is "claims made," CONTRACTOR must, for a period of three (3) years after the date when this Agreement is terminated, completed or non-renewed, maintain insurance with a retroactive date that is on or before the start date of contract services or purchase an extended reporting period endorsement (tail coverage). COUNTY may withhold final payments due until satisfactory evidence of the tail coverage is provided by CONTRACTOR to COUNTY.

VII. Section 15 (NON-DISCRIMINATION IN EMPLOYMENT), subsection G of the Agreement is revised to read as follows:

- G. The CONTRACTOR will include the provisions of Sections 15(A) through (G) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at

41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. CONTRACTOR will take such action with respect to any subcontract or purchase order as COUNTY, Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however that in the event CONTRACTOR becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by COUNTY or DHCS, CONTRACTOR may request in writing to COUNTY, who, in turn, may request DHCS who may in turn request the United States to enter into such litigation to protect the interests of COUNTY, State and of the United States.

VIII. Section 24 (LICENSES, CERTIFICATIONS, AND STAFFING), subsection B of the Agreement is revised to read as follows:

B. CONTRACTOR agrees to provide professional personnel, in accordance with all applicable laws, regulations, and any other requirements, including all amendments thereto, issued by appropriate Federal, State, and COUNTY governmental agencies. In hiring personnel, CONTRACTOR will adhere to State Plan Amendment 23-0026 requirements and any other guidance related to the ninety (90) day rule and monitor registered personnel accordingly. CONTRACTOR shall operate continuously throughout the term of this Agreement with at least the minimum staff required by law for the provision of services hereunder, and if applicable, as indicated in CONTRACTOR's written proposal for services under this Agreement as approved by COUNTY. Such staff shall be qualified in accordance with all applicable laws and regulations.

IX. Section 25 (CLIENT INFORMATION MATERIALS), subsection B (language and Format) of the Agreement is revised to read as follows:

B. Language and Format

- 1) CONTRACTOR shall comply with all applicable State and Federal requirements regarding nondiscrimination, language assistance, information access, including but not limited to the Dymally-Alatorre Bilingual Services Act, Section 1557 of the Patient Protection and Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act.
- 2) CONTRACTOR shall ensure that its written materials for potential clients and clients that are critical to obtaining services, including, at a minimum, provider directories, member handbook, appeal and grievance notices, denial and termination notices, and the CONTRACTOR's mental health education materials, are available in alternative formats at no cost to the client, and comply with the requirements specified in 42 C.F.R.

438.10(d)(6)(ii)), 42 C.F.R. § 438.10(d)(3)), (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Inst. Code § 14727(a)(1); Cal. Code Regs. tit. 9 § 1810.410, subd. (e), para. (4)), and

- 3) CONTRACTOR shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)-(4)).
- 4) CONTRACTOR shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

X. Section 38 (TRANSITION OF CARE TOOL), of the Agreement is revised to read as follows:

38. TRANSITION OF CARE TOOL. CONTRACTOR shall use a Transition of Care Tool for any clients whose existing services will be transferred from Contractor to a Medi-Cal Managed Care Plan (MCP) provider or when non-SMHS will be added to the existing mental health treatment provided by Contractor. CONTRACTOR will follow all DHCS information notices and COUNTY policies and procedures related to Transition of Care to ensure continuity of care.

XI. Section 48 (CONFIDENTIALITY), of the Agreement is revised to read as follows:

48. CONFIDENTIALITY. CONTRACTOR shall maintain the confidentiality of all records and information obtained in the course of providing services to clients, in accordance with the confidentiality and disclosure provisions of applicable law including, but not limited to, Welfare and Institutions Code, Sections 5328 through 5330, inclusive, and all other applicable COUNTY, State, and Federal laws, ordinances, rules, regulations, manuals, guidelines, and directives pertaining to confidentiality. Records and information include, but are not limited to claims, COUNTY records, patient/client records and information, and VCBH Electronic Health Record System records.

XII. Section 55 (TIMELY ACCESS), of the Agreement is revised to read as follows:

55. TIMELY ACCESS. CONTRACTOR shall comply with the requirements set forth in 42 CFR Section 438.206(C)(1) and CCR, Title 9, § 1810.405, including meeting County and State Agreement standards for timely access to care and services, taking into account the urgency of need for services. COUNTY will monitor CONTRACTOR to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.

XIII. Section 60 (RECORDS), Subsection D (RETENTION OF RECORDS), of the Agreement is revised to read as follows:

B. Retention of Records. Upon expiration or termination of this Agreement, CONTRACTOR shall retain all records hereunder in accordance with applicable

Federal, State, COUNTY, and local laws, regulations, requirements, and any amendments thereto, including, but not limited to, the following: all patient/client records, psychologist records, and service and financial records shall be kept for a minimum of ten (10) years from the term end date of this Agreement or, in the event CONTRACTOR has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. In the case of youth records, all member records and psychologist records shall be retained for a minimum of ten (10) years from the term end date of this Agreement or, in the event CONTRACTOR has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, or until the person's 25th birthday, whichever is later.

XIV. Section 65 (REPORTS), Subsection B, of the Agreement is revised to read as follows:

B. CONTRACTOR shall participate in the VCBH Electronic Health Record System, as required by the DIRECTOR. CONTRACTOR shall report to COUNTY, all program, patient/client, staff, and other data and information about CONTRACTOR's services, within the specified time periods as required by COUNTY, and in accordance with any other COUNTY requirements.

XV. Section 68 (FEDERAL SALARY RATE CAP), of the Agreement is revised to read as follows:

68. FEDERAL SALARY RATE CAP. CONTRACTOR agrees that no Federal funds provided under this agreement shall be used by the CONTRACTOR or its subcontractors to pay the salary and wages of an individual at a rate that is in excess of \$221,900 per year, or as adjusted by the Federal government, which is Level II of the Federal Executive Schedule, located at <https://www.opm.gov/> (U.S. Office of Personnel Management).

XVI. Exhibit "A" (PROGRAM DESCRIPTION) of the Agreement is deleted and replaced with the new Exhibit "A" (PROGRAM DESCRIPTION) attached hereto.

XVII. Exhibit "B" (PAYMENT TERMS) of the Agreement is deleted and replaced with the new Exhibit "B" (PAYMENT TERMS) attached hereto.

XVIII. Exhibit "D" (CODE OF CONDUCT) of the Agreement is deleted and replaced with the new Exhibit "D" (CODE OF CONDUCT) attached hereto.

XIX. Exhibit "H" (UTILIZATION REVIEW AND CONTRACTOR'S INVOICE PROCEDURE) of the Agreement is deleted and replaced with the new Exhibit "H" (UTILIZATION REVIEW AND CONTRACTOR'S INVOICE PROCEDURE) attached hereto.

XX. Except for the modifications described herein, all other terms and conditions of the Agreement, as previously amended, shall remain in effect.

- XXI. This Second Amendment may be executed in counterparts, each of which shall constitute an original, and all of which taken together shall constitute one and the same instrument.
- XXII. The parties hereto agree that this Second Amendment may be transmitted and signed by electronic or digital means by either/any or both/all parties and that such signatures shall have the same force and effect as original signatures, in accordance with California Government Code Section 16.5 and California Civil Code Section 1633.7.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF the parties hereto have executed this Second Amendment through their duly authorized representatives as of the last date written below.

GOLDEN VENTURA CRT, LLC.,

COUNTY OF VENTURA

BY

(authorized signature)

(print name and title)

Date

Federal Tax Identification #

BY

(authorized signature)

(print name and title)

Date

EXHIBIT “A”
PROGRAM DESCRIPTION – Amended July 1, 2024

1. INTRODUCTION

- A. As an organizational provider agency, CONTRACTOR shall provide administrative and direct program services to COUNTY’s Medi-Cal clients as defined in Title 9, Division 1, Chapter 11 of the California Code of Regulations.
- B. CONTRACTOR has the option to deliver services using evidence-based program models. CONTRACTOR shall provide said services in CONTRACTOR’s program(s) as described herein; and utilizing locations as described herein.

2. PROGRAM INFORMATION

Contract Period	July 1, 2024 through June 30, 2025
Program Name	Golden Ventura CRT, LLC
Service Delivery Locations	350 Hillmont Avenue, Ventura, CA 93003
Hours of Operation	24/7

3. TARGET POPULATION

- A. CONTRACTOR shall provide services to the following populations:
 - I. CONTRACTOR will provide 24/7 crisis residential treatment services to Ventura County residents ages of 18 and older authorized by COUNTY. The majority of clients will have a serious mental illness and significant functional impairment who are at risk of psychiatric hospitalization but do not require care in a locked treatment setting or who may require an intensive level of support but no longer require treatment in a locked treatment program. Admissions to the CRT program may also include persons with short-term mental health disorders that are at imminent risk of psychiatric hospitalization. Clients shall receive services on a voluntary basis or as authorized by a court appointed conservator. The planned length of stay in the CRT program shall be in accordance with the client’s assessed needs, but not to exceed thirty (30) days, unless circumstances require a longer length of stay to ensure successful completion of the treatment plan and appropriate referrals. For a stay beyond the initial thirty (30) days (and any subsequent thirty-day periods), CONTRACTOR will obtain authorization from COUNTY at least three (3) days prior to the thirty-day stay and will document the reason and the authorization in the client’s health record.

4. SERVICES TO BE PROVIDED

- A. CONTRACTOR shall provide the following medically necessary covered specialty mental health services, as defined in the DHCS Billing Manual available at <https://www.dhcs.ca.gov/provgovpart/Documents/Billing-Manual-v-1-1-June->

2022.pdf, or subsequent updates to this billing manual to clients who meet access criteria for receiving specialty mental health services.

- I. The CRT Program Director or their designee shall work closely with COUNTY staff to develop contracted operational admission and discharge policies and procedures that facilitate the admission, transfer, and discharge of clients. COUNTY will collaborate with CONTRACTOR to clarify and specify admission criteria within the parameters of contracted obligations, effective client services and resource management.
- II. CONTRACTOR shall admit residents according to the following criteria and procedures:
 - a. Adults who carry a primary psychiatric diagnosis meet State Department of Health Care Services Mental Health Division and COUNTY eligibility criteria for services.
 - b. Clients who are residents of Ventura County; and Medi-Cal eligible.
 - c. Adult persons aged eighteen (18) and older consistent with State of California Department of Social Services Community Care Licensing regulations.
 - d. Clients who are appropriate and consistent with CONTRACTOR's admission and exclusionary criteria.
 - e. Clients who are in psychiatric crisis who would otherwise require psychiatric hospitalization; and clients whose behavior, related to a mental disorder, is to the degree that they require supervision for twenty-four (24) hours, seven (7) days a week. This will also include clients who are discharged from an acute psychiatric inpatient facility but continue to require 24/7 supervision.
 - f. Facility access complies with the State of California Department of Health Care Services Mental Health Division requirements related to the Americans with Disabilities Act. Therefore, CONTRACTOR shall admit clients that utilize wheelchairs and walkers within the parameters established by Community Care Licensing.
 - g. Admit only clients who are able to benefit from brief intensive crisis residential services.
- B. CONTRACTOR shall observe and comply with all lockout and non-reimbursable service rules, as specified in the DHCS Billing Manual.
- C. CONTRACTOR shall provide Medication education, training, support, and monitoring/discussing/reviewing side effects can be provided by Clinical Trainees, Licensed Mental Health Professionals (including nurses), Physician Assistants, and Pharmacists.

- I. A Medical Assistant (MA) can provide Medication and Support services if a licensed physician, nurse practitioner, or physician assistant is physically present in the treatment facility during the provision of services by the MA to supervise the staff.
- II. Limitations: The maximum number of hours claimable for medication support services in a 24-hour period is four (4) hours per client.

5. REFERRAL AND INTAKE PROCESS

A. CONTRACTOR shall follow the referral and intake process as specified herein.

- I. Referrals shall be accepted twenty-four (24) hours per day, seven (7) days per week.
- II. The expected sources of COUNTY referrals to the program will be Hillmont Psychiatric Center (HPC), crisis stabilization units, COUNTY outpatient clinics/programs, medical emergency departments, and COUNTY jail. Other potential sources of COUNTY referrals to the program will be considered on a case-by-case basis. Routine COUNTY referrals to the program (i.e., those coming from other facilities that allow for advanced planning) shall be reviewed and decided on by the CONTRACTOR within seventy-two (72) hours.
- III. All COUNTY admissions to the program will require prior authorization by the COUNTY's contract liaison (Behavioral Health Adult Residential Manager, direct 415-254-1578, or 805-981-8823) or the Adult Division Chief (direct 805-320-8261). Once authorized, admission to the program will be coordinated by the CONTRACTOR and COUNTY.

6. PROGRAM DESIGN

A. CONTRACTOR shall maintain programmatic services as described herein.

- I. The primary goal of the Crisis Residential Treatment (CRT) Program is to stabilize clients in acute crises in order to eliminate or shorten the need for inpatient hospitalization. Activities in support of this goal include assessment, community functioning evaluation, mental health counseling (including individual and group therapy and peer support) treatment for co-occurring substance abuse disorders, Wellness and Recovery based group interventions, case management, medication services, and successful linkages to community support services with the goal of minimizing the risk of hospitalization or return to routine crisis-based care.
- II. Services will be based on the Recovery Model of care. Interventions will focus on client empowerment, symptom reduction of barriers to self-sufficiency in the community, and maximization of each client's engagement in his or her recovery. The goal is to improve the quality of their life through strong family/support

person(s) participation in the recovery plan, and by instilling hope for long-term recovery. In this social rehabilitative setting, clients will use the therapeutic community, particularly peer support and group living experiences to develop the skills needed to deal with their current life situation, crisis, or stress.

III. These services are also intended to meet the following goals and objectives:

- a. Provide crisis residential treatment (CRT) services to ensure that clients have a safe, stable, and comfortable short-term (usually less than 30 days) living environment.
- b. Assist at least seventy-five percent (75%) of clients in resolving their psychiatric crisis sufficiently to allow them to successfully transition to less intensive levels of care in the community.
- c. Reduce clients' functional impairment due to psychiatric symptoms (and chemical use/abuse when present).
- d. Assist clients in developing a recovery plan that obtains housing, food, clothing, stable funding, and improved self-sufficiency that is necessary for a successful discharge from the CRT.
- e. Avoid psychiatric hospitalization or criminal incarceration (for behaviors that are related to their mental health impairments) following the stabilization of their psychiatric crisis.
- f. Increase medication effectiveness through increased understanding and adherence by clients; improve access to medical and dental health care. Successfully link clients to outpatient services following discharge such that at least ninety percent (90%) of clients discharged from the CRT program will have an appropriate mental health appointment scheduled within fourteen (14) days.

7. DISCHARGE CRITERIA AND PROCESS

- A. The CONTRACTOR will engage in discharge planning beginning at intake for each client served under this agreement. Discharge planning will include regular reassessment of client functioning, attainment of goals, determination of treatment needs and establishment of discharge goals.
- B. When possible, discharge will include treatment at a lower level of care or intensity appropriate to client's needs and provision of additional referrals to community resources for client to utilize after discharge.
- I. Planned Discharges: Client shall normally be discharged in a planned, coordinated manner, agreed upon in advance and in conjunction with COUNTY staff, mostly commonly via the Continuum of Care meeting held Wednesday at

10AM. Discharge planning shall begin at admission; however, linkages to community resources that support the recovery plan should be included, including but not limited to housing, behavioral health services (mental health, substance use, medication, case management, peer support, family support), physical health, benefits, vocational services, etc.. Input by, and participation of, all CONTRACTOR staff (e.g. clinical, peer, family) in the development of the plan will be essential to effective linkage and coordination with follow-up COUNTY providers. Length of stay shall be based on medical necessity criteria for CRT level of care. The discharge date will be established when the treatment team, including the client, client's family/support persons (when available), CRT staff and COUNTY staff determines that the client is able to live at a less intensive level of care, most commonly within 30 days of admission. The CRT staff shall assist with discharge placements by taking the resident to visit potential placements and by transporting the resident to the placement at time of discharge.

- II. Unplanned Discharges: If a resident at any time presents as a serious danger to self or to others or is seriously or repetitively non-compliant with the program, discharge from the program may take place. In such circumstances staff will assess the safety needs of all concerned and take the appropriate action. Unplanned discharges will occur after all other available actions have failed. CONTRACTOR shall provide protocols for client property and the means to return said property to the client in the event that said property is left at the facility.
- III. CONTRACTOR shall provide a written discharge summary that includes a summary of reason for admission, treatment provided, discharge plan, medication prescribed, and any discharge medications or prescriptions provided upon discharge to the follow-up VCBH program within two (2) business days. In the event of unplanned discharges, the CONTRACTOR shall immediately notify any current COUNTY program in which the client is known to have an active treatment episode prior to admission in the CRT or for which was actively involved in discharge planning prior to the client's departure from the CRT.
- IV. CONTRACTOR shall notify law enforcement and any private or public conservator (e.g., Public Guardian) immediately if a client who presents an imminent risk to self or others, elopes from the facility, so that an assessment under the provisions of Welfare and Institutions Code Section 5150 can be done. CONTRACTOR shall also notify the client's involved family members, and Community Care Licensing Division, and COUNTY within 12 hours, or the next business day, under these circumstances.

8. PROGRAM OR SERVICE SPECIFIC AUTHORIZATION REQUIREMENTS

- A. All COUNTY admissions to the program will require prior authorization by the COUNTY's contract liaison (Behavioral Health Adult Residential Manager, direct 415-254-1578, or 805-981-8823) or the Adult Division Chief (direct 805-320-8261). Once authorized, admission to the program will be coordinated by the CONTRACTOR and COUNTY.

9. CONTRACT DELIVERABLES, OBJECTIVES AND OUTCOMES

- A. CONTRACTOR shall comply with all requests regarding local, State, and Federal performance outcomes measurement requirements and participate in the outcomes measurement processes as requested.
- B. CONTRACTOR shall work collaboratively with COUNTY to develop process benchmarks and monitor progress in the following areas:
 - I. All treatment and services will be provided with sensitivity to the clients' culture in a manner that promotes self-sufficiency, wellness, and recovery with attention to maximizing the existing social and environmental supports and client strengths.
 - II. Individuals admitted to the CRT Program shall receive a mental health assessment and psychiatric assessment, including a screening for medical conditions, within 24 hours of admission normally, and in no case more than 72 hours after admission.
 - III. Within 24 to 72 hours after admission, CRT staff shall complete a Community Functioning Evaluation of community living needs and identify barriers to discharge to the community.
 - IV. Service Planning:
 - a. Within 24 to 72 hours, CRT staff shall develop a Wellness and Recovery Service Plan establishing goals to be accomplished during the clients' stay in the program. The service plan, which must include a discharge plan, will be developed in collaboration with the client, participating family/significant other, LPS conservator (if applicable) and CRT staff. Plan development should include participation by peer staff, including a peer family advocate; whenever family or significant other engagement, support and participation are identified as a need. Activities related to effective discharge (housing, linkage) shall commence as soon as the plan is developed. The service plan will identify client strengths and responsibilities, articulate any participating family/support persons' responsibilities, and reflect the client's goals. Service plans shall be updated as needed in accordance with sound clinical practice and Medi-Cal requirements during the client's length of stay.
 - b. Within 24 to 72 hours of admission, and with client consent, CRT staff will attempt to contact and involve the client's family and support persons. The service plan will clearly identify the participating family and support persons' role(s) and responsibilities in the client's recovery. When clients refuse to consent to family or significant other's involvement in their treatment and discharge planning, and the clinical staff determine that family/significant other participation would appear to be a beneficial component of the client's current recovery needs, the CRT staff will document in the client's chart the rationale and recommendation for family/significant other participation in the recovery

plan and the daily efforts to inform the client of the potential benefit of family/significant other inclusion in an effort to engage the client in benefiting from available support systems and to obtain consent. Engagement effort will occur daily, until that consent is obtained, or the client is discharged.

- V. Clients will be asked to consent to test for the presence of alcohol and drugs upon admission as part of the assessment process, development of a multi-axial diagnosis and service plan, including the need for substance use or dependency treatment. Alcohol and drug test results obtained within 24 hours of admission by other health care providers will be acceptable in meeting this requirement.

10. REPORTING AND EVALUATION REQUIREMENTS

- A. CONTRACTOR shall complete all reporting and evaluation activities as required by the COUNTY and described herein.
 - I. CONTRACTOR shall adhere to the COUNTY's documentation and billing standards as outlined in the COUNTY's Compliance Training which will be provided to CONTRACTOR and submit proof of each staff's training to COUNTY upon initial training and annually thereafter.
 - II. CONTRACTOR will regularly attend the Adult Services Sub Committee of the Behavioral Health Advisory Board and will present program outcomes to the committee as requested.
 - III. CONTRACTOR shall complete the mandatory performance measures: upon intake and discharge, for each client authorized by COUNTY for Medi-Cal Mental Health Services. CONTRACTOR will input data into the Milestones of Recovery Scale (MORS). COUNTY will consult with CONTRACTOR on establishing a system for data collection and data integrity measures. CONTRACTOR may petition COUNTY to accept alternative performance measures. CONTRACTOR is responsible for the mandatory measures until written acceptance of the proposed alternative measures from the COUNTY Director or Designee has been received.
 - IV. CONTRACTOR will provide a Quarterly Report to COUNTY no later than the 15th day of the month after the end of each quarter (Oct. 15th, Jan. 15th, April 15th, and July 15th). COUNTY will inform CONTRACTOR of the required content of the Quarterly report which will include at minimum: number of clients referred and accepted; time to service data, length of stay, placement at discharge and date and type of referral appointments at time of discharge, and number of unusual occurrence reports.
 - V. CONTRACTOR agrees to comply with COUNTY policies and procedures of the "Advance Directives."
 - VI. CONTRACTOR shall enter billing data into the Netsmart Billing System and will submit total number of units provided to clients referred through this contract by

service code (i.e., collateral, individual, etc.) and submit to COUNTY on a monthly basis along with their General Claim form.

- VII. COUNTY and CONTRACTOR agree to meet on an ongoing basis to negotiate concerns related to this Agreement, including but not limited to concerns regarding treatment coordination, service utilization and outcomes, documentation and reporting requirements, financing, and revenue production.

11. ORIENTATION, TRAINING AND TECHNICAL ASSISTANCE

- A. COUNTY will endeavor to provide CONTRACTOR with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement and (b) conduct the quality management activities called for by the Agreement.
- B. COUNTY will provide the CONTRACTOR with all applicable standards for the delivery and accurate documentation of services.
- C. COUNTY will make ongoing technical assistance available in the form of direct consultation to CONTRACTOR upon CONTRACTOR's request to the extent that COUNTY has capacity and capability to provide this assistance. In doing so, COUNTY is not relieving CONTRACTOR of its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement.
- D. Any requests for technical assistance by the CONTRACTOR regarding any part of this agreement shall be directed to the COUNTY's designated contract monitor.
- E. CONTRACTOR shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first thirty (30) days of their first day of work. CONTRACTOR shall require all covered individuals to attend, at minimum, one (1) compliance training annually.
- I. This training shall be conducted by the COUNTY, at COUNTY's discretion, by CONTRACTOR staff, or both, and may address any standards contained in this agreement.
- II. Covered individuals who are subject to this training are any CONTRACTOR staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.

EXHIBIT "B"
PAYMENT TERMS
GOLDEN VENTURA CRT, LLC.,
Amended July 1, 2024

- A. COUNTY shall pay CONTRACTOR in accordance with the terms and conditions set forth in this Exhibit "B" and Attachment A to Exhibit "B" for CONTRACTOR's satisfactory performance or provision of the services and work described in Exhibit "A". Except as expressly provided in this Agreement, the maximum total sum of all payments made by COUNTY to CONTRACTOR for the services and work performed or provided under this Agreement for the service period of July 1, 2024 through June 30, 2025, shall not exceed **\$2,370,000**. This not to exceed amount is not a guaranteed sum but shall be paid only for services actually rendered. Any unspent fiscal year appropriation does not roll over and is not available for services provided in subsequent years. The funding sources for this Agreement could include SD/MC FFP and MHSA.
- B. CONTRACTOR shall enter claims data into COUNTY's Electronic Health Record System within the timeframes established by COUNTY. CONTRACTOR shall use CPT or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual available at <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>, as from time to time amended. CONTRACTOR will review the DHCS Billing Manual periodically to ensure CONTRACTOR is aware of any changes and utilizing the information from the most current version of the manual.
- C. CONTRACTOR shall bill COUNTY monthly in arrears by invoice using CONTRACTOR's own letterhead or format and include a signed Certification of Claims form (Exhibit "I") and a printout from COUNTY's Electronic Health Record System of billable services (invoices shall be based on claims entered into the COUNTY's Electronic Health Record System for the prior month). COUNTY will complete a reconciliation of the units of service and rates against the payments made to CONTRACTOR to identify any over or under payments. COUNTY is entitled to recover, and CONTRACTOR shall remit any amount overpaid to CONTRACTOR within forty-five (45) days of any COUNTY completed reconciliation. COUNTY will remit any additional payments required to the CONTRACTOR upon any COUNTY completed reconciliation.

All invoices submitted shall clearly reflect all required information regarding the services for which invoices are made, in the form and content specified by COUNTY. CONTRACTOR shall submit delivered units of service with appropriate documentation, along with the invoice for reimbursement. No service that has been or will be reimbursed by any other revenue source can be invoiced by CONTRACTOR. Invoices for reimbursement shall be completed by CONTRACTOR, and dated, and forwarded to COUNTY within ten (10) working days after the close of the month in which services were rendered. Incomplete or incorrect invoices shall be returned to CONTRACTOR for correction and resubmittal and will result in payment delay. Late invoices will also result in payment delays. Following receipt of a complete and correct monthly invoice and approval by COUNTY, CONTRACTOR shall then be paid within forty-five (45) working days of submission of a valid invoice to the COUNTY.

- D. **TIMELY BILLING.** CONTRACTOR shall generate a monthly Timely Billing Report for Outpatient Programs that has been reviewed by CONTRACTOR's Chief Financial Officer, Controller, or highest-ranking accounting officer. CONTRACTOR's accounting officer's signature on the report indicates that timeliness related to billing will be managed to achieve an average of three business days or less for full-use users of the County Electronic Health Record System and an average of six (6) business days or less for billing-only users of the County Electronic Health Records System, from the time of service to the date of entry in COUNTY's Electronic Health Record System. The signed Timely Billing Report must be attached with the monthly invoice and submitted to COUNTY. CONTRACTOR shall ensure that all data is entered in a timely manner in order to produce the most accurate reports.
- E. Payment shall be made in arrears upon the submission of approved invoices to COUNTY. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the COUNTY's Electronic Health Record System. The payment is based on the day rate and provider type hourly rates as detailed in Table 1, in Attachment A to Exhibit "B." COUNTY's payments to CONTRACTOR for performance of claimed services are provisional and subject to adjustment until the completion of all reconciliation activities. COUNTY's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this Agreement or the reasons for recoupment set forth in Section 62, Audit of Services, Subsections D and E. All payments shall be subject to audit and reconciliation. COUNTY agrees to pay CONTRACTOR for approved services rendered, less any services that are disallowed for any reason by the COUNTY Quality Assurance Division. CONTRACTOR shall be liable for any expenses incurred by CONTRACTOR in excess of the contract maximum. In no event shall the maximum amount payable hereunder exceed the maximum contract amount under this Agreement, as specified in Section A of Exhibit "B."
- F. CONTRACTOR has submitted to COUNTY for its review and consideration a budget that contains estimated staffing which is applicable under this Agreement. COUNTY will use this information as an ongoing monitoring guide and will also include in COUNTY monitoring the measure of productivity, service level expectation, and the ability to achieve outcomes as specified in this Agreement.
- G. **SD/MC reimbursement provision:** For Medi-Cal eligible services COUNTY acknowledges its responsibility to pay CONTRACTOR with respect to services provided to Medi-Cal members under this Agreement, CONTRACTOR shall comply with Medi-Cal State Plan and Medi-Cal SMHS Waiver requirements. The Short-Doyle/Medi-Cal reimbursement is composed of FFP and Local Matching Funds (County Resources). COUNTY requests that CONTRACTOR maximize services under this Agreement utilizing Short-Doyle/Medi-Cal funding as applicable. CONTRACTOR must accept as payment in full the amounts paid by COUNTY in accordance with this Agreement. CONTRACTOR may not demand any additional payment from DHCS, client, or other third-party payers.
- H. CONTRACTOR may not redirect or transfer funds from one funded program to another funded program under which CONTRACTOR provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.

- I. CONTRACTOR may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.
- J. It is expressly understood and agreed between the parties hereto that COUNTY shall make no payment and has no obligation to make payment to CONTRACTOR unless the services provided by CONTRACTOR hereunder were authorized by DIRECTOR or his or her designee prior to performance thereof.
- K. CONTRACTOR or subcontractor of CONTRACTOR shall not submit a claim to, or demand or otherwise collect reimbursement from, the member or persons acting on behalf of the member for any SMHS or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (CCR, tit 9 Section 1810.365(a)).
- L. CONTRACTOR shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, CONTRACTOR shall use the uniform billing and collection guidelines prescribed by DHCS.
- M. CONTRACTOR or subcontractor of CONTRACTOR shall not hold members liable for debts in the event that the COUNTY becomes insolvent; for costs of covered services for which the State does not pay the COUNTY; for costs of covered services for which the State or the COUNTY does not pay the COUNTY's network providers; for costs of covered services provided under a contract, referral or other arrangement rather than from the COUNTY; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a member. 42 CFR 438.106 and Cal Code Regs Title 9 1810.365(c).
- N. CONTRACTOR agrees to hold harmless both the State of California and members in the event the COUNTY cannot or does not pay for services performed by the CONTRACTOR pursuant to this Agreement.
- O. This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or State or Federal funding sources that may in any way affect the fiscal provisions of or funding for this Agreement. This Agreement is also contingent upon sufficient funds being made available by COUNTY or State or Federal funding sources for the term of the Agreement. If the Federal or State governments reduce financial participation in the Medi-Cal program, COUNTY agrees to meet with CONTRACTOR to discuss renegotiating the services required by this Agreement.
- P. COUNTY will not remit payment for services to any entity or financial institution that is located outside of the United States of America. CONTRACTOR certifies, by executing this Agreement, that it and its subcontractors are located (and, where CONTRACTOR and/or its subcontractors are corporations, incorporated) in the United States of America.
- Q. COUNTY will not remit payment for services furnished to an excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing

the service knew or had reason to know of the exclusion, or to an individual or entity when the State Department of Health Care Services or COUNTY failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. section 1396b(i)(2)).

- R. In accordance with 42 C.F.R. 438.608(a)(8) and 42 C.F.R. part 455.23, in cases where there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against CONTRACTOR or their network provider, COUNTY shall suspend all payments to CONTRACTOR, unless there is good cause not to suspend payments or to suspend payment only in part.
- S. COUNTY will not remit payment for any item or service furnished under this Agreement: (1) by CONTRACTOR or any individual or entity during any period when CONTRACTOR, the individual, or entity is excluded from participation under the Social Security Act, sections 1128, 1128A, 1156 or 1842(j)(2), (2) that is provided by any individual, entity, at the medical direction or on the prescription of a physician, during the period when the individual, entity, or physician is excluded from participation under titles V, XVIII, or XX or pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such items or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person), (3) if the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual, entity, or physician, unless the State determines there is good cause not suspend such payments, or (4) in respect to any services or activities furnished for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
- T. In the event that CONTRACTOR fails to comply with any provision of this Agreement, including the timely submission of any and all reports, records, documents, or any other information as required by County, State, and appropriate Federal agencies regarding CONTRACTOR's activities and operations as they relate to CONTRACTOR's performance of this Agreement, COUNTY shall withhold payment until such noncompliance has been corrected.
- U. CONTRACTOR hereby acknowledges that all claims for payment for services rendered shall be in accordance with Exhibit "I" (Certification of Claims for Payment for Services Rendered), attached hereto and made a part hereof by this reference.
- V. Notwithstanding any other provision of this Agreement, SD/MC services provided hereunder by CONTRACTOR, shall comply with and be compensated in accordance with all applicable Federal, State, and COUNTY laws, regulations, requirements, and any amendments or changes thereto, including but not limited to, DHCS SD/MC, Medi-Cal SMHS title 9, Chapter 11, DMH Cost Reporting Data Collection Manual, title 19 of the Social Security Act, title 22 of the California Code of Regulations, Section 51516, and policy letters issued by the DMH-DHCS, Program regulations and requirements as specified by DMH-DHCS. It is understood that such services will subsequently be billed by COUNTY for SD/MC FFP.

- W. CONTRACTOR shall ensure that all services provided under this Agreement which are eligible for SD/MC FFP reimbursement shall be reported to COUNTY in accordance with COUNTY reporting timelines, instructions, and formats. COUNTY in its sole discretion may withhold payment to CONTRACTOR if CONTRACTOR does not comply with such reporting timelines, instructions, and formats as required by COUNTY. COUNTY shall be responsible for billing the appropriate entity for reimbursement of the SD/MC services provided and reported by CONTRACTOR to COUNTY.
- X. CONTRACTOR understands and agrees that all SD/MC FFP revenue generated by the services provided by CONTRACTOR under this Agreement shall be reimbursed to COUNTY.
- Y. Notwithstanding any other provision of this Agreement, in no event shall COUNTY be liable or responsible to CONTRACTOR for any payment for any disallowed SD/MC services provided hereunder, which are the result of CONTRACTOR's sole negligence in providing SD/MC services under this Agreement. CONTRACTOR shall be required to fully reimburse COUNTY for any payment by COUNTY to CONTRACTOR that is subsequently disallowed through Federal, State, county or any other entity audit(s) or review(s) including any services that are disallowed for any reason by the VCBH Quality Assurance Division.
- Z. Claims deemed unallowable shall be subject to recoupment or recovery by COUNTY.
- AA. CONTRACTOR shall not bill members for covered services under a contractual, referral, or other arrangement with COUNTY in excess of the amount that would be owed by the individual if the COUNTY had directly provided the services (42 U.S.C 1396u-2(b)(6)(C)).
- BB. COUNTY and CONTRACTOR agree to meet on an ongoing basis to negotiate concerns related to this Agreement, including but not limited to treatment coordination, service utilization and outcomes, documentation and reporting requirements.
- CC. CONTRACTOR will fund the purchase of replacement furniture/fixtures for the contracted facility through the approved maximum contract amount/budget. CONTRACTOR will ensure that all emergency furniture/fixtures that require replacement are replaced in a timely manner. Pre-approval for any furniture/fixture replacement costs that exceed the maximum contract amount/budget will need to be presented to the COUNTY for approval and consideration of a contract increase or COUNTY will replace the furniture/fixtures directly.

**ATTACHMENT A TO EXHIBIT “B”
 PROVIDER SERVICE RATES
 GOLDEN VENTURA CRT, LLC
 Amended July 1, 2024**

- A. Table 1: Provider Rates lists the day rate and provider type hourly rates, as determined by the correct Taxonomy Code for the provider type scope of practice. The day rate and provider type are the basis for the reimbursement of the allowed services/procedures that CONTRACTOR is authorized to provide per this Agreement and the DHCS Billing Manual.

Table 1: Provider Rates		
Service Category	Unit Rate	Contract Maximum
Crisis Residential		
24 Hour Services	\$464.84	
Medication Education Services		
Registered Nurses	\$359.02	
Nurse Practitioner	\$440.51	
Licensed Vocational Nurses	\$189.02	
Total Contract Maximum		\$2,370,000

EXHIBIT "D"



CODE OF CONDUCT





Mission

Provide comprehensive, cost-effective, compassionate health care for our diverse community, especially those facing barriers, through an exceptional workforce, education, and forward-thinking leadership.

Vision

Setting the standard in health care excellence. Healthy people in healthy communities throughout Ventura County

CODE OF CONDUCT SERVICE EXPERIENCE

Ventura County Health Care Agency's (HCA) employees and agents shall strive to deliver quality, patient-centered health care services.

- Patients have the right to choose their health care. Patients will be involved in decisions regarding their care to the greatest practical extent possible.
- No person shall be denied care by HCA solely based on race, gender, religion, creed, color, economic status, or source and amount of payment. Further, employees are to be impartial and are not to discriminate in providing service based on race, color, national origin, religion, ancestry, medical condition, gender, sexual orientation, age, marital status, or disability.
- HCA employees and its agents will seek to understand and respect a patient's objectives for care and shall treat patients in a manner respecting their background, culture, religion, and heritage.
- HCA's employees and agents shall treat all patients with dignity, respect, and courteousness.
- Patients have the right to information for informed health care decisions including therapeutic alternatives and risks associated with their care. Patients also have a right to receive information about HCA's policies, procedures, and charges.
- Quality patient care will only be delivered by qualified, competent staff.
- HCA will maintain an accurate medical record for each patient that is promptly completed, accessible, and retained.

CODE OF CONDUCT BUSINESS PRACTICES

HCA's employees and agents shall comply with all applicable laws and regulations.

- HCA, by and through its employees and agents, shall comply with all applicable laws, regulations, standards, and other requirements including those of Federal and State health care programs.
- Employees or agents who perform billing and/or coding of claims must take reasonable precautions to ensure that their work is accurate, timely, and in compliance with federal and state laws and regulations and policies.
- HCA will bill only for services rendered and which are fully documented in the patient's medical records. If the services are coded, then only billing codes that accurately describe the services provided will be used.
- No claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate, or fictitious will be submitted. No falsification of medical conditions, services, time, or other records that are the basis of claims submission will be tolerated.
- HCA shall act promptly to investigate and correct the problem when errors in claims that have been submitted are discovered.
- All reports or other information required to be provided to any federal, state, or local government agency shall be accurate, complete, and timely filed, including the reporting of overpayments related to the Medicare and Medicaid Programs.
- HCA shall maintain a complete and thorough medical and billing record and ensure they are retained according to regulatory requirements and organizational policy.
- HCA will seek positive relationships with government programs and third-party payers including ongoing communication about patient progress and billing.
- No employee or agent is authorized to enter any joint venture, partnership or other risk sharing arrangement with any entity that is a potential or actual referral source unless the arrangement has been reviewed and approved by County Counsel and the Board of Supervisors.

CODE OF CONDUCT BUSINESS PRACTICES

HCA's employees and agents shall engage in ethical business relationships including maintaining confidentiality.

- Employees and agents must perform their duties in a way that promotes the public's trust in HCA.
- The Federal government prohibits payment for services provided by an individual or entity that the government has excluded from participating in a Federally funded health care program. HCA will not knowingly employ, conduct business with or contract with excluded providers.
- HCA's employees and agents shall comply with all laws governing the confidentiality of medical information.
- Employees or agents shall not use or reveal any confidential information obtained as an employee or agent of HCA concerning HCA or its patients.
- HCA, in accordance with Title 22, Section 70707 of the California Code of Regulations, believes that the patient has the right to full consideration of privacy concerning their health care.
- No employee or agent should subordinate his or her professional standards, or objectivity to any individual. If significant differences of opinion in professional judgment occur, then they should be referred to management for resolution.
- Employees and agents should be honest and forthright in any representations made to patients, vendors, payers, other employees or agents, and the community.
- Each employee or agent has an obligation to the citizens, to the people's elected representatives, to fellow employees, and to the County's administration, to accomplish its goals, to expose corruption wherever discovered, to refrain from disclosure of any confidential information, to preserve and safeguard the County's assets, and to uphold these principles, ever conscious that public office is a public trust.

CODE OF CONDUCT CONFLICTS OF INTEREST

Employees and agents must avoid situations in which their interests' conflict with the duty to act in HCA's best interest.

- Employees and agents should report any potential conflicts of interest concerning themselves or their family members to HCA in accordance with the Conflict-of-Interest Code.
- Employees and agents should avoid any activity that conflicts with the interests of HCA or its patients. Even the appearance of impropriety should be avoided. If an employee or agent suspects that a conflict may exist or be created, then he or she should consult with management.
- Employees and agents should not have other jobs that interfere with their ability to perform their duties at HCA.
- Employees and agents should not become involved, directly, or indirectly, in outside commercial activities that could improperly influence their actions or otherwise conflict with the Conflict-of-Interest Code without first disclosing that relationship to management.
- Conducting business with any firm in which there is a family relationship may constitute a conflict of interest. Advance disclosure and approval may be required as set forth in Ventura's Conflict of Interest Code for the Health Care Agency (Conflict of Interest Code).
- Employees and agents should not accept or provide benefits that could be seen as creating conflict between their personal interests and legitimate business interests. This includes accepting expensive meals, gifts, refreshments, transportation, or entertainment in connection with the job.
- No employee shall accept any fee, compensation, payment of expense, or any other item of monetary value in which acceptance may result in, or create the appearance of resulting in, the use of public office for private gain; preferential treatment of any person, impeding governmental efficiency or economy; any loss of complete independence or impartiality; the making of a County decision outside official channels; or any adverse effect on the confidence of the public in the integrity of County government.
- Gifts and benefits to clinicians or referral sources are not appropriate.

CODE OF CONDUCT

PROTECTION AND USE OF INFORMATION, PROPERTY AND ASSETS

HCA's employees and agents shall protect the County's property and respect the property rights of others.

- HCA will not pursue any business opportunity that requires engaging in unethical or illegal activity.
- Employees and agents must obtain authorization prior to committing or spending HCA's funds.
- Employees and agents are personally responsible and accountable for the proper expenditure of HCA funds and for the proper use of its property.
- Employees and agents may not use either HCA or patient resources for personal or improper purposes or permit others to do so.
- HCA equipment is intended to be used only for HCA or County business.
- Use of electronic assets is for business. Employees and agents may only use computer systems and networks, in a manner consistent with HCA's policies, and shall take reasonable steps to protect systems and software from unauthorized access or intrusion. Misuse will result in disciplinary action in accordance with HCA policy.
- Surplus, obsolete, or junked property shall be disposed of in accordance with HCA's and County's procedures. Unauthorized disposal is a misuse of assets.
- Employees and agents have a duty to be productive during work time.
- Any improper financial gain through misconduct involving misuse of either HCA's or a patient's property is prohibited, including the theft of property or of money.
- HCA's confidential and proprietary information is valuable and should be protected from unauthorized use or exploitation. Employees and agents are also expected to respect the intellectual property rights of others with whom HCA does business.
- Employees and agents are expected to report any observed misuse of property to their supervisor or through the Compliance Line established for reporting concerns, including anonymously.
- Reasonable meal expenditures or entertainment must comply with the County Reimbursement Policy.

CODE OF CONDUCT HUMAN RESOURCES

HCA's employees and agents shall respect each other as human beings and health care professionals.

- Applicants and employees shall be afforded equal employment and advancement opportunities, pursuant to policies.
- Employees and agents are expected to conform to the standards of their respective professions and exercise sound judgment in the performance of their duties. Any differences of opinion in professional judgment should be referred to appropriate management levels for resolution in accordance with standard grievance procedures.
- All employees and agents should show proper respect and consideration for each other, regardless of position. Discriminatory treatment, harassment, abuse, or intimidation will not be tolerated. Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature are serious violations of the standards of conduct and will not be condoned or permitted.
- Employees will be provided with reasonable accommodation, as outlined by the provisions of the Americans with Disabilities Act of 1990 (ADA) and/or California Fair Employment and Housing Act (FEHA). As an employer, we are responsible for providing reasonable accommodations to the known physical or mental impairments of a qualified individual with a disability, unless doing so would impose an undue hardship on the operation of County business.
- HCA will contribute to an employee's or agent's competence by making available continuing job-related education and training (within the limits of its resources).
- HCA will not permit any action of retaliation or reprisal against an employee who reports a violation of law, policy, or procedure.

CODE OF CONDUCT HEALTH AND SAFETY

Our highest priority is the health and safety of our patients and ourselves. We shall strive to do our jobs so that no harm is caused to our patients, the public, or ourselves.

- Employees and agents are expected to comply with all work and safety rules.
- HCA shall only employ or work with people with proper credentials, experience, and expertise.
- HCA is a drug and alcohol-free workplace.
- Smoking is not permitted near any entrance to any HCA buildings or vehicles.
- Drugs, including controlled substances and other pharmaceuticals shall be safely stored, secured, dispensed, and inventoried in conformance with all applicable laws and regulations. Shortages and missing items shall be reported promptly to supervisors.
- Medical and/or County waste or other hazardous materials shall be disposed of properly and lawfully.

CODE OF CONDUCT REPORTING CONCERNS

Employees and agents shall promptly report all suspected violations of the Code of Conduct, Compliance Guidelines, operational policies, laws, or regulations to their manager or supervisor, through the confidential Compliance Line or to the Compliance Officer. You are protected from retaliation if you make a good-faith report.

- One option is to speak with your supervisor or another manager. If you are not comfortable speaking with him/her, or you believe the matter has not been adequately resolved, you should contact the Compliance Officer.
- If you want to anonymously report a concern, HCA has a third-party that takes confidential reports at 1.888.488.3146. This number is available 24 hours a day, seven days a week. Reports will be forwarded to the Compliance Department for investigation and resolution. You may remain anonymous if you choose, however if you identify yourself, it may assist in the investigation of the matter.
- Retaliation against any employee who, in good faith, reports potential or suspected violations is unlawful and will not be tolerated.

ATTESTATION OF COMPLIANCE

I agree to comply with the Code of Conduct. I represent that I am in complete compliance with the requirements of the Code of Conduct as it applies to my job responsibilities.

I also represent and warrant that I have not been excluded from, or sanctioned by, any Federal health care benefits program, including but not limited to Medicare, Medi-Cal, CHAMPUS or the federal retired railway workers benefit program.

Signature

Date

EXHIBIT “H”
UTILIZATION REVIEW AND CONTRACTORS INVOICE PROCEDURE
Amended July 1, 2024

1. Utilization Review staff will contact CONTRACTOR to schedule the chart review site visits.
2. A random selection of charts documenting services provided the previous month will be reviewed, per COUNTY policy.
3. **For out of county contractors** who are not directly entering billing into the VCBH Electronic Health Record System, all clinical documentation for the previous month, including updated treatment plans and assessments, will be encrypted and emailed securely to VCBH Quality Assurance Utilization Review at QM.UR@ventura.org.
4. CONTRACTOR will submit its monthly invoice(s) to VCBH Fiscal Administration Accounts Payable by email to: bh_accountspayable@ventura.org or by mail to:

Ventura County Behavioral Health
Fiscal Administration Accounts Payable
1911 Williams Drive, Suite 210
Oxnard, CA 93036

Invoices **MUST** include the following information: (1) remit to name and address, (2) invoice date, (3) invoice number, (4) Federal identification number, (5) service month, (6) rate(s), (7) units of service, and (8) Electronic Health Record System report from the County system that demonstrates and ties to the specific units of service that are included in the invoice.

5. Utilization Review staff will review documentation for compliance with the Department of Health Care Services documentation standards and notify CONTRACTOR of any out of compliance items via a “Chart Remediation” memo, on a quarterly basis. If the CONTRACTOR does not remediate issues and demonstrates continuous areas of concern and/or disallowances, the frequency of the Utilization Reviews may increase. Items that may be corrected to prevent disallowance of units will be identified and CONTRACTOR will have two (2) weeks to return evidence of correction to the Utilization Review office.
6. Items that are not remediated or cannot be corrected will be noted and units will be disallowed from CONTRACTOR’s invoice. CONTRACTOR’s invoice will be reduced to reflect the reduction of the disallowed units multiplied by the associated unit rate of service.