Stanislaus County Behavioral Health and Recovery Services
1601 I St. Suite 200
Modesto, CA 95350
209-525-6225

Re: Letter of Agreement for SMHS for out-of-county youth placed at STRTP

This letter serves as an agreement between Mendocino County Behavioral Health and Recovery Services (BHRS) ("Payer") and Stanislaus County ("Provider"), to provide Specialty Mental Health Services (SMHS) to Mendocino County foster youth placed in Short Term Residential Therapeutic Programs (STRTP) in Stanislaus County. Services under this Agreement may be provided by the "Provider" and/or a contracted provider who contracts directly with the "Provider."

Terms of Agreement

This Agreement authorizes medically necessary Specialty Mental Health Services (SMHS). The term of the Agreement shall be from 07/01/2026 to 06/30/2029. The contract maximum amount for this Agreement shall not exceed $150,000 under the rate terms for the authorized period. Recommendations for continued treatment and/or higher level of care treatment will be sent by the Provider to BHRS for renewal and/or authorization. BHRS shall not be responsible for payment of fees for any services provided beyond the term of this Agreement, unless BHRS first approves an extension of treatment. Similarly, BHRS shall not be responsible for payment of fees for treatment at a higher level of care, unless the Provider obtains prior authorization from BHRS for the treatment.

Rate Terms

Services are to be provided by Stanislaus County's contracted provider/s:

- Stanislaus County Tax ID: 94-600532
- Rate: Mendocino County will pay Stanislaus County the Federal Financial Participation (FFP) match (County portion) according to provider rates established by the Department of Health Care Services (DHCS).
- Location: 1120 S Dora St, Ukiah, CA 95482

Reimbursement Process

Provider shall process the SMHS Medi-Cal billings, pay the contracted provider, as applicable, and then invoice (Attachment 1) BHRS for the costs of local match (i.e., remaining costs not covered through Federal Financial Participation and/or State General Fund, where applicable). BHRS will reimburse Provider based upon submitted invoices that shall reflect the costs of local match incurred by Provider through their payment for services to a contracted provider within Stanislaus County.

All invoices and supporting documents submitted in the format directed by BHRS shall clearly report all required information specified regarding the services for which claims are made. To ensure timely payment for services, services should be billed to BHRS within thirty (30) days of receipt of the corresponding 835 form from the Department of Health Care Services. Invoices for payment shall be submitted via encrypted email to:

QAQI@mendocinocounty.gov

Provider agrees in no event, to bill, charge, collect a deposit, no-show fee, or reimbursement from the client or have any recourse against a client, or person acting on client's behalf, for services provided pursuant to this Agreement. Provider will not receive payment for client no show or denied claims. Invoices will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, federal and state billing and payment rules.

Services

SMHS provided to children or youth in foster care that are covered under this Agreement include the following:

- Assessment
- Psychiatric Evaluations
- Plan Development
- Therapy (Individual, Group, and Family)
- Rehabilitation Services, including Intensive Home Based Services (IHBS) and Therapeutic Behavioral Services (TBS)
- Targeted Case Management, including Intensive Care Coordination
- Psychiatrist Services and related Medication Support Services
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization Unit

Coordination of Care

Provider will work with BHRS for coordination and continuity of care. If the Provider feels that the client requires treatment in addition to authorized treatment described in this Agreement, the Provider will notify BHRS of recommended treatment and additional service recommendations. BHRS will review the request and decide whether to authorize the recommended treatment and/or services.

Authorization Renewal

If Provider believes, it is medically necessary for client to obtain services beyond those described or beyond the dates of service authorized in this Agreement, Provider must obtain an additional authorization from BHRS to be eligible to receive reimbursement. Provider is encouraged to submit requests thirty (30) days prior to end of authorization to avoid disruption in client treatment. Provider will not receive payment for additional services outside of this authorization until authorization renewal is approved.

Utilization Review

Provider agrees to cooperate with BHRS staff by timely and comprehensively responding to BHRS requests for review and validation of service delivery and to assure compliance with applicable state or federal laws, rules, and regulations and Medi-Cal documentation standards. All documentation should have the name of the client, duration of session, Current Procedural Terminology code, and location of service, along with any other documentation standard such as a wet signature or electronic signature of client. Payment can be denied if medical necessity is not established, or validation of service delivery is not present in documentation. Provider is responsible for ongoing oversight and monitoring of the STRTP including ensuring STRTP staff are properly credentialed per Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 18-019 (Attachment 2).

Credentialing and Re-Credentialing

Provider must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified. Network providers must be in good standing with the Medicaid/Medi-Cal programs. Any provider excluded from participation in federal health care programs, including Medicare or Medicaid/Medi-Cal, may not provide services under this Agreement.

The uniform credentialing and re-credentialing requirements in the MHSUDS Information Notice 18-019 (Attachment 2) apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers contracting with BHRS to deliver Medi-Cal covered services.

https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-019%20PROVIDER%20CREDENTIALING%20AND%20RE-CREDENTIALING/MHSUDS_Information%20Notice_18-019_Final%20Rule_Credentialing.pdf

Medi-Cal Certification

1. Execution of Agreement is contingent upon Stanislaus County ("Provider") maintaining Medi-Cal Certification with the contracted provider who contracts directly with Provider.

2. Provider shall ensure their Medi-Cal certified contracted provider is in compliance with all federal and state laws and regulations pertaining to Short Doyle Medi-Cal during the term of this Agreement. For example, the storage and dispensing of medications on site shall be in compliance with all applicable state and federal standards.

3. Provider shall notify BHRS QAQI Unit in writing of anticipated changes at least sixty (60) days prior to any changes related to the contracted provider's Medi-Cal Certification. Such changes include, without limitation, a change to the contracted provider's Medi-Cal certification, including termination, and termination of the Provider's contract with contracted provider.

4. Provider is to notify BHRS of any notifications or changes received from DHCS related to the contracted providers' Medi-Cal certification.

5. Provider agrees to cooperate with BHRS QAQI staff and other representatives of Mendocino County BHRS to permit access to contracted provider locations for any onsite visits to ensure compliance with applicable state and federal laws, rules, and regulations and Medi-Cal certification standards.

Termination of Treatment

Provider shall notify BHRS prior to the discharge of client and shall allow designated BHRS staff to attend any discharge or treatment meetings regarding the client served under this Agreement. Provider is encouraged to collaborate with BHRS to ensure safe discharge.

Either party may terminate this Agreement, with or without cause, by giving thirty (30) days prior written notice to the other party as long as the parties jointly develop and agree to a transition plan for the youth. Mendocino County BHRS may suspend or terminate this Agreement for cause upon written notice to Provider immediately, or upon such notice, as Mendocino County BHRS deems reasonable. If the default is cured by Provider to the satisfaction of BHRS, or BHRS determines that the default should be excused, BHRS may reinstate the Agreement, or revoke the termination upon application by Provider.

Confidentiality

Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, shall be kept confidential.

Mutual Indemnification

To the fullest extent permitted by law, Provider shall defend, indemnify, and hold harmless Mendocino County BHRS and its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorneys' fees, arising out of, resulting from, or in connection with the performance of this Agreement by Provider or Provider's officers, employees, agents, representatives, or subcontractors (including contracted providers), including, without limitation, those resulting in or attributable to personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use.

To the fullest extent permitted by law, Mendocino County BHRS shall defend, indemnify, and hold harmless the Provider and its officers, employees, agents, representatives, or subcontractors from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorney's fees, arising out of or resulting from the gross negligence or willful misconduct of Mendocino County BHRS and its officers or employee.

COUNTY OF MENDOCINO

Jenine Miller, Psy.D.,
Director of Health Services

COUNTY OF STANISLAUS

Ruben Imperial (Jun 4, 2026 10:54:03 PDT)

Ruben Imperial, MBA
Behavioral Health Director

Shaun Wahid 6.2.26

Shaun Wahid
Chief Deputy County Counsel

IN WITNESS WHEREOF

DEPARTMENT FISCAL REVIEW:

By: _____
Jennie Miller, Psy.D.,
Director of Health Services

Date: 6/30/26

Budgeted: Yes
Budget Unit: 4050
Line Item: 86-3280
Org/Object Code: MH
Grant: No
Grant No.: 'N/A'

County of Stanislaus

By: Ruben Imperial (Jun 4, 2026 10:54:03 PDT)
Ruben Imperial, MBA
Behavioral Health Director

Date: _____

NAME AND ADDRESS OF CONTRACTOR:

County of Stanislaus
1601 I Street, Suite 200
Modesto, CA 95354
209-525-6026

COUNTY OF MENDOCINO

By: _____
BERNIE NORVELL, Chair
BOARD OF SUPERVISORS

Date: _____

ATTEST: SARA PIERCE, Interim
~~DARCIE ANTLE~~, Clerk of said Board

By: _____
Deputy

I hereby certify that according to the provisions of Government Code section 25103, delivery of this document has been made.
SARA PIERCE, Interim
~~DARCIE ANTLE~~, Clerk of said Board

By: _____
Deputy

By signing above, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement

COUNTY COUNSEL REVIEW:

APPROVED AS TO FORM:

By: _____
COUNTY COUNSEL

Date: 06/19/2026

INSURANCE REVIEW:

By: Darcie Antle
Risk Management

Date: 06/19/2026

EXECUTIVE OFFICE/FISCAL REVIEW:

By: Darcie Antle
Deputy CEO or Designee

Date: 06/19/2026

Signatory Authority: $0-25,000 Department; $25,001-$75,000 Purchasing Agent; $75,001+ Board of Supervisors

Mendocino County BHRS
Services Contract Claim Form

Submit Invoice to:	Mendocino County – BHRS Attn: Jenine Miller 1120 S. Dora Street Ukiah California	**Contractor:**	Name Attn: Contact Address City, State, Zip

Type of Service	Date of Service	Rate	Total

Contractor's Signature: _____ Date: _____

Approved By: _____ Date: _____

ACCOUNTS PAYABLE USE ONLY	
Date Paid	
Contract Number	
Batch Number	
Control Number	
Account String	
Description	

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: April 24, 2018

MHSUDS INFORMATION NOTICE NO.: 18-019

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: PROVIDER CREDENTIALING AND RE-CREDENTIALING FOR MENTAL HEALTH PLANS (MHPs) AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PILOT COUNTIES

PURPOSE

The purpose of this Mental Health and Substance Use Disorders Services Information Notice (IN) is to inform county Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) pilot counties, herein referred to as Plans unless otherwise specified, of the Department of Health Care Services' (DHCS) statewide uniform provider credentialing and re-credentialing requirements, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214.

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Final Rule), which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. County MHPs and DMC-ODS pilot counties are considered Prepaid Inpatient Health Plans, and must therefore comply with federal managed care requirements (with some exceptions).

This IN also includes policy changes DHCS has made for compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

Mental Health & Substance Use Disorder Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 319-8219
Internet Address: www.dhcs.ca.gov

On March 30, 2016, CMS issued the Parity Rule in the Federal Register (81.Fed.Reg. 18390) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program.

The Managed Care Final Rule[1] requires the State to establish a uniform credentialing and re-credentialing policy that addresses behavioral health and substance use disorder services providers.

The credentialing process is one component of the comprehensive quality improvement system included in all Plan contracts. The credentialing process may include registration, certification, licensure, and/or professional association membership. Credentialing ensures that providers are licensed, registered, waivered, and/or certified as required by state and federal law.

REQUIREMENTS

Plans must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified.[2] These providers must be in good standing with the Medicaid/Medi-Cal programs. Any provider excluded from participation in Federal health care programs, including Medicare or Medicaid/Medi-Cal, may not participate in any Plan's provider network. For the purposes of this IN, network providers include county-owned and operated providers (i.e., MHP employees) and contracted organizational providers, provider groups, and individual practitioners.

The uniform credentialing and re-credentialing requirements in this IN apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers[3] employed by or contracting with the Plan to deliver Medi-Cal covered services. Effective immediately, Plans must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of their providers in accordance with the policy outlined in this IN.

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[1] 42 C.F.R. §438.214
[2] State Plan, Section 3, Supplement 3 to Attachment 3.1-A,
[3] Applicable provider types include licensed, registered, or waivered mental health providers, licensed practitioners of healing arts, and registered or certified Alcohol or Other Drug counselors.

CREDENTIALING POLICY

For all licensed, waivered, registered and/or certified providers[4], the Plan must verify and document the following items through a primary source,[5] as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, Plans must verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

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[4] For SUD, providers delivering covered services are defined in Title 22 of the California Code of Regulations, Section 51051.

[5] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

Attestation
For all network providers who deliver covered services, each provider's application to contract with the Plan must include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation[6];
2. A history of loss of license or felony conviction;[7]
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

Provider Re-credentialing
DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The Plan must require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

Provider Credentialing and Re-credentialing Procedures
A Plan may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the Plan remains contractually responsible for the completeness and accuracy of these activities. If the Plan delegates credential verification activities to a subcontractor, it shall establish a formal and detailed agreement with the entity performing those activities. To ensure accountability for these activities, the Plan must establish a system that:

- Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensures that the subcontractor meets the Plan's and DHCS' standards; and

[6] These attestation requirements comply with requirements of the Americans with Disabilities Act, 42 U.S.C. §§ 12101 *et seq*.
[7] A felony conviction does not automatically exclude a provider from participation in the Plan's network. However, in accordance with 42 C.F.R. §§ 438.214(d), 438.610(a) and (b), and 438.808(b), Plans may not employ or contract with individuals excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

- Continuously monitors, evaluates, and approves the delegated functions.

Plans are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contract requirements as well as DHCS guidance, including applicable INs.

Each Plan must maintain a system for reporting serious quality deficiencies that result in suspension or termination of a provider to DHCS, and other authorities as appropriate. Each Plan must maintain policies and procedures for disciplinary actions, including reducing, suspending, or terminating a provider's privileges. Plans must implement and maintain a process by which providers may appeal credentialing decisions, including decisions to deny a provider's credentialing application, or suspend or terminate a provider's previously approved credentialing approval.

If you have any questions regarding this IN, please contact the Mental Health Services Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov or the Substance Use Disorder Program, Policy and Fiscal Division at (916) 327-8608 or DMCODSWaiver@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services