GERALD HUBER
Director
GRHuber@solanocounty.com
(707) 784-8400

ROGER ROBINSON
Assistant Director
RERobinson@SolanoCounty.com

DEPARTMENT OF HEALTH & SOCIAL SERVICES
Behavioral Health Services Division

SOLANO COUNTY

EMERY COWAN, LPCC
Chief Deputy, Behavioral Health
ECowan@solanocounty.com

JENNIFER MULLANE, LPCC, M-RAS
Deputy Director, Behavioral Health
JMullane@solanocounty.com

(707) 784-8320
www.solanocounty.com/depts/bh

July 18, 2024

(SAMPLE) County
Behavioral Health Services
ADDRESS

Re: Letter of Agreement for SMHS for youth placed at STRTP

This letter serves as a one-time authorization between Solano County Behavioral Health Services (SCBHS) (Payor) and County Behavioral Health Services (Provider) to provide services for Solano County dependent NAME (Client). The contracted provider will provide services under this agreement, such as a short-term residential therapeutic program (STRTP), which contracts directly with County Behavioral Health.

Terms of Agreement

This agreement authorizes medically necessary Specialty Mental Health Services (SMHS). The contract shall be from 7/8/24 to 1/8/25, not to exceed $75,000 under the rate terms for the authorized period. Recommendations for continued treatment beyond the initial 6-month authorization period and above the initial authorization limit must be mutually agreed upon by Solano County Child Welfare Services (CWS) and STRTP and requested in advance by (DATE).

Rate Terms

All services are to be provided by STRTP, including psychiatric services, and claimed to the California Department of Health Care Services (DHCS) through Provider. SCBHS will reimburse the Provider for the Federal Financial Participation (FFP) match according to provider rates established by the DHCS.

County Tax ID:
County NPI:
Location:

Client Information

Name: XXXXX
DOB: XXXXX
Medi-Cal CIN: XXXXX

STRTP Information:

STRTP Name:
Contact:
Address:
Phone:
Email:

Claim Practices

Provider shall submit invoices via the CalMHSA Presumptive Transfer (PT) Portal or to Solano County Behavioral Health:

Mailing Address:
HIPAA Compliant Fax:

Select Preferred Reimbursement Method:

☒ Provider will use the CalMHSA PT Portal for invoicing Payer
☐ Provider will submit invoices via mail/secure fax

To ensure timely payment of services, services should be billed to SCBHS within 30 days of receipt of the corresponding 835 form from DHCS.

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 the client's behalf for services provided under this Agreement. Provider will not receive payment for client no-shows or denied claims. Claims 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.

If submitting claims via fax/mail and not via the CalMHSA PT Portal, the provider shall submit claims on the attached Vendor Claim, which will be submitted via (INFO). The provider can verify the receipt and status of the claim by calling (INFO).

Coordination of Care

The provider will work with SCBHS to coordinate and maintain continuity of care. Suppose the provider feels that the client requires treatment in addition to the authorized treatment described in this agreement. In that case, the provider will discuss this with Solano County CWS and notify SCBHS of the recommended treatment and additional service recommendations. SCBHSS will review the request and decide.

Authorization Renewal

Suppose the provider believes it is medically necessary for the client to obtain services beyond those described or the dates of service authorized in this Agreement. In that case, XXXX must obtain additional authorization from SCBHS to be eligible for reimbursement. Providers are encouraged to submit requests 30 days before the end of

approval to avoid disruption in client treatment. Provider will not receive payment for additional services outside this authorization until authorization renewal is approved.

Utilization Review

Provider agrees to cooperate with SCBHS medical director, utilization review staff, and other representatives of SCBHS by timely and comprehensively responding to SCBHS 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 client's name, duration of session, CPT code, location of service, and any other documentation standard, such as a wet signature or electronic signature of the client. Payment can be denied if medical necessity is not established or validation of service delivery is not present in documentation. The provider is responsible for the ongoing oversight and monitoring of the STRTP, including ensuring that STRTP staff are adequately credentialed per BHIN 18-019.

Termination of Treatment

The provider shall notify SCBHS before the client's discharge and allow designated SCBHS staff to attend any discharge or treatment meetings regarding the client served under this Agreement. It is encouraged that the Provider will collaborate with SCBHS to ensure safe discharge.

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, will be kept confidential.

Additional Reference Information

DHCS SMHS Rates: Medi-Cal Behavioral Health Fee Schedules FY24-25

Solano County

Signature: _____

Name: _____

Title: _____

Date: _____

Provider: _____

Signature: _____

Name: _____

Title: _____

Date: _____

NPI: _____