THIRD AMENDMENT TO THE
AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

THIS THIRD AMENDMENT to the Agreement for Services of Independent Contractor, **BC # 22-008**, is made by and between the **County of Santa Barbara** (County) and **PathPoint** (Contractor) for the continued provision of services specified herein (hereafter, Third Amended Agreement).

WHEREAS, Contractor represents that it is specially trained, skilled, experienced, and competent to perform the special services required by County, and County desires to retain the services of Contractor pursuant to the terms, covenants, and conditions referenced herein; and

WHEREAS, on May 31, 2022, the County Board of Supervisors authorized the County to enter into an Agreement for Services of Independent Contractor with **PathPoint** (BC # 22-008) (hereafter, Agreement) for the provision of mental health and residential supported housing services for a maximum contract amount not to exceed **$7,697,685**, inclusive of $2,565,895 per fiscal year, for the period of July 1, 2022, through June 30, 2025; and

WHEREAS, on October 17, 2023, the County Board of Supervisors approved a First Amendment to the Agreement (hereafter, First Amended Agreement) to update the language in the Mental Health Services General Provisions, Statement of Work for Adult Housing Support Program, and Statement of Work for Supported Community Services South; update the program name from Supportive Community Services South to South Community Full Service Partnership; add client expense funds for Full Service Partnerships; implement California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Payment Reform changes; and add $949,124 per fiscal year in Mental Health Services funding for FY 23-24 and 24-25, for a revised total maximum contract amount not to exceed **$9,595,933**, inclusive of $2,565,895 for FY 22-23; $3,515,019 for FY 23-24; and $3,515,019 for FY 24-25, for the period of July 1, 2022, through June 30, 2025; and

WHEREAS, on June 18, 2024, the County Board of Supervisors approved a Second Amendment to the Agreement (hereafter, Second Amended Agreement) by template to add contingency payment and contingency cost settlement provisions and incorporate changes for Medicare practitioner billing and State rate changes with no change to the maximum contract amount and contract term, and the Second Amended Agreement using the template was executed on June 27, 2024; and

WHEREAS, through this Third Amended Agreement, the County and Contractor desire to increase pay rates to Contractor staff and add an additional incentive for Full Service Partnership requirements by adding language for Full Service Partnership (FSP) Incentive Payment to MHS Financial Provisions for FY 23-25, and adding $98,856 to the contract maximum for a revised total maximum contract amount not to exceed **$9,694,789**, inclusive of $2,565,895 for FY 22-23; $3,515,019 for FY 23-24; and $3,613,875 for FY 24-25, with no change to the contract term.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, County and Contractor agree as follows:

I. Delete Section II, Maximum Contract Amount, of Exhibit B – FY 23-25 (Financial Provisions – MHS) and replace with the following:

II. MAXIMUM CONTRACT AMOUNT.

The Maximum Contract Amount of this Agreement shall not exceed $9,694,789, inclusive of $2,565,895 for FY 22-23, $3,515,019 for FY 23-24, and $3,613,875 for FY 25-25, for the period of July 1, 2022 through June 30, 2025, and shall consist of County, State, and/or Federal funds as shown in Exhibit B-1–MHS and subject to the provisions in Section I (Payment for Services). Notwithstanding any other provision of this Agreement, in no event shall County pay Contractor more than this Maximum Contract Amount for Contractor's performance hereunder without a properly executed amendment.

II. Delete Section V, Quality Assurance (QA)/Utilization Management (UM) Incentive Payment, of Exhibit B-FY 23-25 (Financial Provisions -MHS) and replace with the following:

V. QUALITY ASSURANCE (QA)/ UTILIZATION MANAGEMENT (UM) INCENTIVE PAYMENT.

A. For Medi-Cal programs, County will provide Contractor with an incentive payment at fiscal year-end should the following deliverables be achieved. The incentive payment will be equal to 4% of total approved Medi-Cal claims (2% Quality Assurance and 2% Utilization Management) and will be payable upon proof of completion of deliverables and conclusion of regular Medi-Cal claiming for the fiscal period. The incentive payment will not be applied to unclaimed and/or denied services. Documentation must be maintained to substantiate completion of the deliverables.

1. QA deliverables include:

   i. Contractor shall hire or designate existing staff to implement quality assurance type activities. The designated QA staff member shall be communicated to the County.

   ii. Contractor shall provide a monthly report to QCM consisting of documentation reviews performed, associated findings, and corrective action. The QA reports shall be received by County no later than 30 calendar days following the end of the month being reported.

   iii. Contractor QA staff shall attend bi-monthly County Quality Improvement Committee (QIC) meetings. Attendance is to be monitored via sign-in sheets.

2. UM deliverables include:

   i. Contractor shall hire or utilize existing staff to implement utilization management type activities. The designated UM staff member shall be communicated to the County.

   ii. For programs with practitioner billing, Contractor shall implement procedures to monitor productivity including the submission of monthly reports on productivity for each direct service staff member (direct billed hours to total paid hours). Total paid hours is equal to 2,080 per full-time equivalent (FTE) position and should be adjusted for part-time employment. Reports will be due within 30 calendar days following the end of the reporting month.

iii. For 24-hour programs, Contractor shall implement procedures to monitor bed occupancy including the submission of monthly reports on bed vacancies and reasons for vacancies. Reports should detail the dates of client discharges and notifications provided to the County. Reports will be due within 30 calendar days following the end of the reporting month.

B. For Medi-Cal Full Service Partnership Programs, County will provide Contractor with an incentive payment at fiscal year-end should the following deliverables be achieved. The incentive payment will be equal to an additional 6% of total approved Medi-Cal claims (6% FSP QA claim) and will be payable upon proof of completion of deliverables and conclusion of regular Medi-Cal claiming for the fiscal period. The incentive payment will not be applied to unclaimed and/or denied services. Documentation must be maintained to substantiate completion of the deliverables.

1. FSP QA deliverables include:

   i. Contractor will report quarterly on additional client outcomes concerning specific, measurable outcomes for clients engaged in purposeful activities. Exact additional outcomes will be determined by Contractor and BWell director or designee.

   ii. Contractor will create an annual report that measures growth in client's engagement in purposeful activity.

   iii. Contractor will attend monthly meetings in which the Contractor and County will conduct a consistent review of clients who have been in the programs for two years or longer and do a case review to see which level of care they need.

   iv. Contractor will report the results of the monthly utilization review on a quarterly basis to County.

C. The Behavioral Wellness Director or designee may reallocate between the contract allocations on the Exhibit B-1 MHS at his/her discretion to increase or decrease the incentive payment. Reallocation of the contract allocations does not alter the Maximum Contract Amount and does not require an amendment to this Agreement.

III. Delete Exhibit B-1-MHS – FY 23-25 Schedule of Rates and Contract Maximum in its entirety and replace it with the following:

Exhibit B-1-MHS-FY 23-24
Schedule of Rates and Contract Maxium
(Applicable to programs described in Exhibit A2-A4)

EXHIBIT B-1 MH
DEPARTMENT OF BEHAVIORAL WELLNESS
SCHEDULE OF RATES AND CONTRACT MAXIMUM

CONTRACTOR NAME: Pathpoint **FISCAL YEAR:** 2023-2024

Contracted Service	Service Type	Provider Group	Practitioner Type	Full Time Equivalent Staffing	Hourly Rate (Avg. Direct Bill rate)	Medi-Cal Target Hours	Medi-Cal Contract Allocation
Medi-Cal Billable Services	24-Hour Services	24-Hour Services	Adult Residential	n/a	$228.00	7,115	$1,622,141
	Outpatient Services Fee-For-Service	Non-Prescriber	Registered Nurse	2.00	$293.23	1,103	$323,438
			Licensed Vocational Nurse	0.00	$161.51	0	$0
			Licensed Psychiatric Technician	0.00	$137.99	0	$0
		Behavioral Health Provider	Psychologist/ Pre-licensed Psychologist	0.00	$290.10	0	$0
			LPHA / Assoc. LPHA	1.60	$197.58	883	$174,464
			Certified Peer Recovery Specialist	0.00	$156.81	0	$0
			Rehabilitation Specialists & Other Qualified Providers	12.50	$148.97	6,895	$1,027,145
				16.10		**8,881**	**$3,147,187**

Contracted Service	Service Type	Program(s)	Reimbursement Method	Non-Medi-Cal Contract Allocation
Non-Medi-Cal Billable Services	Outpatient Non-Medi-Cal Services (1)	All Programs at 2%	Fee-For-Service	$62,944
	Board and Care - Indigent Clients (2)	Phoenix and Mountain Houses	SSI Rate	$40,000
	Quality Assurance & Utilization Management (3)	All Programs at 4%	Incentive	$125,887
	Client Flexible Funds (4)	Supportive Community Services	Cost Reimbursement	$139,000
				$367,831

Total Contract Maximum **$3,515,019**

Contract Maximum by Program & Estimated Funding Sources							
	PROGRAM(S)						Total
Funding Sources (5)	Supportive Community Services (Paths to Recovery)	Residential Support Services	Phoenix House Supportive Services	Mountain House Supportive Services			
Medi-Cal Patient Revenue (6)	$ 1,350,583	$ 174,464	$ 748,680	$ 873,461			$ 3,147,187
MHSA QA / UM Incentive	$ 54,023	$ 6,979	$ 29,947	$ 34,938			$ 125,887
MHSA Non-Medi-Cal Services	$ 27,012	$ 3,489	$ 14,974	$ 17,469			$ 62,944
MHSA Board and Care	$ -	$ -	$ 20,000	$ 20,000			$ 40,000
MHSA Client Flexible Support	$ 139,000	$ -	$ -	$ -			$ 139,000
TOTAL CONTRACT PAYABLE PER FY:	**$ 1,570,618**	**$ 184,932**	**$ 813,601**	**$ 945,868**	**$ -**	**$ -**	**$ 3,515,019**

CONTRACTOR SIGNATURE: Signed by: Harry Brull DocuSigned by:

FISCAL SERVICES SIGNATURE: 0BEA3DC498F54B8... Christie Boyer 96D40AB0C0AD408...

(1) Outpatient Non-Medi-Cal service allocation is intended to cover services provided to Non-Medi-Cal client services at the same Fee-For-Services rates as noted for Medi-Cal clients.

(2) Board and care allocation is intended to cover indigent clients at the SSI rate which is currently $1,324 per month. Rate may be adjusted in January of each year to match State/Federal schedules. Contractor shall confirm client indigent status with County prior to placement in an indigent bed for costs to be reimbursable. Director or designee has the right to reallocate flexible funds between adult residential facilities and/or reallocate additional funds from other funding sources, subject to the contract maximum, should board and care costs exceed the amount estimated in the Exhibit B-1.

(3) Quality Assurance and Utilization Management incentive payment requires the implementation of specific deliverables. If deliverables are not met then contractor is not eligible for incentive payment. Refer to Exhibit B, Section V of the agreement for required deliverables.

(4) Client flexible support costs must comply with Behavioral Wellness policy guidelines. Supporting documentation is to be maintained by the contractor with costs tracked separately and monthly financial statements submitted.

(5) The Director or designee may reallocate between funding sources at his/her discretion during the term of the contract, including to utilize and maximize any additional funding or FFP provided by local, State, or Federal law, regulation, policy, procedure, or program. Reallocation of funding sources does not alter the Maximum Contract Amount and does not require an amendment to the contract.

(6) Source of Medi-Cal match is State and Local Funds including but not limited to Realignment, MHSA, General Fund, Grants, Other Departmental Funds and SB 163.

Exhibit B-1-MHS - FY 24-25
Schedule of Rates and Contract Maximum (Continued)
(Applicable to programs described in Exhibit A2-A4)

EXHIBIT B-1 MH
DEPARTMENT OF BEHAVIORAL WELLNESS
SCHEDULE OF RATES AND CONTRACT MAXIMUM

CONTRACTOR NAME: Pathpoint

FISCAL YEAR: 2024-2025

Contracted Service	Service Type	Provider Group (7)	Practitioner Type	Full Time Equivalent Staffing	Hourly Rate (Avg. Direct Bill rate)	Medi-Cal Target Hours	Medi-Cal Contract Allocation
Medi-Cal Billable Services	24-Hour Services	24-Hour Services	Adult Residential	n/a	$228.00	7,115	$1,622,141
	Outpatient Services Fee-For-Service	Non-Prescriber	Registered Nurse	2.00	$329.99	604	$199,315
			Licensed Vocational Nurse	0.00	$173.35	0	$0
			Licensed Psychiatric Technician	0.00	$148.61	0	$0
		Behavioral Health Provider	Psychologist/ Pre-licensed Psychologist	0.00	$326.73	0	$0
			LPHA / Assoc. LPHA	1.60	$211.43	934	$197,478
			Certified Peer Recovery Specialist	0.00	$167.03	0	$0
			Rehabilitation Specialists & Other Qualified Providers	13.00	$159.08	7,585	$1,206,651
				16.60		**9,123**	**$3,225,585**

Contracted Service	Service Type	Program(s)	Reimbursement Method	Non-Medi-Cal Contract Allocation
Non-Medi-Cal Billable Services	Outpatient Non-Medi-Cal Services (1)	All Programs at 2%	Fee-For-Service	$64,512
	Board and Care - Indigent Clients (2)	Phoenix and Mountain House	SSI Rate	$40,000
	Quality Assurance & Utilization Management (3)	All Programs at 4%	Incentive	$129,021
	Full Service Partnership Incentive (3)	Supportive Community Services at 6%	Incentive	$85,257
	Client Flexible Funds (4)	Supportive Community Services	Cost Reimbursement	$69,500
				$388,290

Total Contract Maximum **$3,613,875**

Contract Maximum by Program & Estimated Funding Sources							
	PROGRAM(S)						Total
Funding Sources (5)	Supportive Community Services (Paths to Recovery)	Residential Support Services	Phoenix House Supportive Services	Mountain House Supportive Services			
Medi-Cal Patient Revenue (6)	$ 1,420,965	$ 182,478	$ 748,680	$ 873,461			$ 3,225,585
MHSA QA / UM Incentive	$ 56,838	$ 7,298	$ 29,947	$ 34,938			$ 129,021
MHSA FSP Incentive	$ 85,257	$ -	$ -	$ -			$ 85,257
MHSA Non-Medi-Cal Services	$ 28,419	$ 3,650	$ 14,974	$ 17,469			$ 64,511
MHSA Board and Care	$ -	$ -	$ 20,000	$ 20,000			$ 40,000
MHSA Client Flexible Support	$ 69,500	$ -	$ -	$ -			$ 69,500
TOTAL CONTRACT PAYABLE FY 24-	**$ 1,650,979**	**$ 193,426**	**$ 813,601**	**$ 945,868**	**$ -**	**$ -**	**$ 3,613,875**

CONTRACTOR SIGNATURE: DocuSigned by: Harry Bruell

FISCAL SERVICES SIGNATURE: Christie Boyes 6BEA0DC498F54BB...

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(1) Outpatient Non-Medi-Cal service allocation is intended to cover services provided to Non-Medi-Cal client services at the same Fee-For-Services rates as noted for Medi-Cal clients.

(2) Board and care allocation is intended to cover indigent clients at the SSI rate which is currently $1,398 per month. Rate may be adjusted in January of each year to match State/Federal schedules. Contractor shall confirm client indigent status with County prior to placement in an indigent bed for costs to be reimbursable. Director or designee has the right to reallocate flexible funds between adult residential facilities and/or reallocate additional funds from other funding sources, subject to the contract maximum, should board and care costs exceed the amount estimated in the Exhibit B-1.

(3) Quality Assurance, Utilization Management, and Full Service Partnership incentive payments require the implementation of specific deliverables. If deliverables are not met then contractor is not eligible for incentive payment. Refer to Exhibit B of the agreement for required deliverables.

(4) Client flexible support costs must comply with Behavioral Wellness policy guidelines. Supporting documentation is to be maintained by the contractor with costs tracked separately and monthly financial statements submitted.

(5) The Director or designee may reallocate between funding sources at his/her discretion during the term of the contract, including to utilize and maximize any additional funding or FFP provided by local, State, or Federal law, regulation, policy, procedure, or program. Reallocation of funding sources does not alter the Maximum Contract Amount and does not require an amendment to the contract.

(6) Source of Medi-Cal match is State and Local Funds including but not limited to Realignment, MHSA, General Fund, Grants, Other Departmental Funds and SB 163.

(7) Refer to taxonomy codes in Exhibit B-3 for billable practitioner types within each provider group.

IV. Delete Exhibit B-3 for FY 23-25 Entity Rates and Codes by Service Type in its entirety and replace it with the following:

Exhibit B-3 – MHS – FY 23-25
Entity Rates and Codes by Service Type
Behavioral Health Provider Fees

Behavioral Health Provider Fees

Provider type	FY 23-24 Hourly Rate (Avg. Direct Bill rate)	FY 24-25 Hourly Rate (Avg. Direct Bill	Taxonomy Codes
Psychologist/ Pre-licensed Psychologist	$290.10	$326.73	102L, 103G, 103T
LPHA	$197.58	$211.43	1012, 101Y, 102X, 103K, 106H, 1714, 222Q, 225C, 2256
LCSW	$197.58	$211.43	106E, 1041
Peer Recovery Specialist	$156.81	$167.03	175T
Mental Health Rehabilitation Specialist	$148.97	$159.08	146D, 146L, 146M, 146N, 171M, 174H, 1837, 2217, 224Y 224Z, 2254, 2258, 225A, 2260, 2263, 246Y, 246Z, 2470, 274K, 374T, 376K, 3902, 4053
Other Qualified Providers	$148.97	$159.08	171R, 172V,3726, 373H, 374U, 376J

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
90785	Interactive Complexity	Supplemental Service Codes	Occurrence
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15
90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27
90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45
90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60
90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52
90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30
90845	Psychoanalysis, 15 Minutes	Therapy Codes	15
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50
90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15
90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15
90885	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	Assessment Codes	15
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15
96105	Assessment of Aphasia, per Hour	Assessment Codes	60
96110	Developmental Screening, 15 Minutes	Assessment Codes	15
96112	Developmental Testing, First Hour	Assessment Codes	60
96113	Developmental Testing, Each Additional 30 Minutes	Assessment Codes	30
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60
96125	Standardized Cognitive Performance Testing, per Hour	Assessment Codes	60
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15
96130	Psychological Testing Evaluation, First Hour	Assessment Codes	60
96131	Psychological Testing Evaluation, Each Additional Hour	Assessment Codes	60
96132	Neuropsychological Testing Evaluation, First Hour	Assessment Codes	60
96133	Neuropsychological Testing Evaluation, Each Additional Hour	Assessment Codes	60
96136	Psychological or Neuropsychological Test Administration, First 30 Minutes	Assessment Codes	30
96137	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30
96146	Psychological or Neuropsychological Test Administration, 15 Minutes	Assessment Codes	15
96161	Caregiver Assessment Administration n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15
98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8

Exhibit B-3 – MHS – FY 23-25
Entity Rates and Codes by Service Type
Behavioral Health Provider Fees (Continued)

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16
98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Plan Development Codes	60
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	Plan Development Codes	60
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60
G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes *(automatically added by SmartCare as appropriate)*	Add-on Code	15
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Peer Support Services Codes	15
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15
H0038	Self-help/peer services per 15 minutes	Peer Support Services Codes	15
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15

(1) The State Department of Health Care Services (DHCS) routinely updates CPT and HCPC codes. Refer to the DHCS County Claims Customer Services Library 'Specialty Mental Health Services Table' online at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx for a complete list of codes and associated billing requirements.

Exhibit B-3 – MHS – FY 23-25
Entity Rates and Codes by Service Type –
Non-Prescriber Fees

Non-Prescriber Fees

Provider type	FY 23-24 Hourly Rate (Avg. Direct Bill rate)	FY 24-25 Hourly Rate (Avg. Direct Bill rate)	Taxonomy Codes
Registered Nurse	$293.23	$329.99	163W, 3675,
Licensed Vocational Nurse	$161.51	$173.35	164W, 164X
Licensed Psychiatric Technician	$137.99	$148.61	106S, 167G, 3747

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
90785	Interactive Complexity	Supplemental Service Codes	Occurrence
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15
96110	Developmental Screening, 15 Minutes	Assessment Codes	15
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15
96138	Psychological or Neuropsychological Test Administration by Technician, First 30 Minutes	Assessment Codes	30
96139	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30
96161	Caregiver Assessment Administratio n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15
96365	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis, 1-60 Minutes	Medication Support Codes	46
96366	Intravenous Infusion, for Therapy, Prophylaxis, Each Additional 30-60 Minutes past 96365	Medication Support Codes	45
96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Additional Sequential Infusion, 1-60 Minutes after 96365	Medication Support Codes	31
96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Concurrent Infusion, 15 Minutes	Medication Support Codes	15
96369	Subcutaneous Infusion for Therapy or Prophylaxis, Initial, 15-60 Minutes	Medication Support Codes	38
96370	Subcutaneous Infusion for Therapy or Prophylaxis, Each Additional 30-60 Minutes after 96369	Medication Support Codes	45
96371	Subcutaneous Infusion for Therapy or Prophylaxis, Additional Pump Set-Up, 15 Minutes	Medication Support Codes	15
96372	Therapeutic, Prophylactic, or Diagnostic Injection; Subcutaneous or Intramuscular, 15 Minutes. Do not use this code to indicate administration of vaccines/toxoids or intradermal cancer immunotherapy injection.	Medication Support Codes	15
96373	Therapeutic, Prophylactic, or Diagnostic Injection; Intra- Arterial, 15 Minutes	Medication Support Codes	15
96374	Therapeutic, Prophylactic, or Diagnostic Injection; Intravenous Push, Single or Initial Substance/Drug, 15 Minutes	Medication Support Codes	15
96375	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Push of a New Substance/Drug, 15 Minutes	Medication Support Codes	15
96376	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Drug Provided in a Facility; Has to be More than 30 Minutes after a Reported Push of the Same Drug, 1- 14 Minutes	Medication Support Codes	15

Code (1)	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate
96377	Application of On- body Injector for Timed Subcutaneous Injection, 15 Minutes	Medication Support Codes	15
99366	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Face-to-face with Patient and/or Family. 30 Minutes or More	Plan Development Codes	60
99368	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	Plan Development Codes	60
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60
99605	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with New Patient with Assessment and Intervention, 15 Minutes	Medication Support Codes	15
99606	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with Established Patient with Assessment and Intervention, 15 Minutes	Medication Support Codes	15
99607	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with Patient with Assessment and Intervention, each Additional 15 Minutes beyond 99605 or 99606.	Medication Support Codes	15
G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes *(automatically added by SmartCare as appropriate)*	Add-on Code	15
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15
H0034	Medication Training and Support, per 15 Minutes	Medication Support Codes	15
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15
T1001	Nursing Assessment/Evaluation, 15 Minutes	Assessment Codes	15
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15

(1) The State Department of Health Care Services (DHCS) routinely updates CPT and HCPC codes. Refer to the DHCS County Claims Customer Services Library 'Specialty Mental Health Services Table' online at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx for a complete list of codes and associated billing requirements.

V. **Effectiveness**. The terms and provisions set forth in this Third Amended Agreement shall modify and supersede all inconsistent terms and provisions set forth in the original and First and Second Amended Agreements. The terms and provisions of the Agreement, except as expressly modified and superseded by the First, Second, and Third Amended Agreements, are ratified and confirmed and shall continue in full force and effect and shall continue to be legal, valid, binding, and enforceable obligations of the parties.

VI. Execution of Counterparts. This Third Amended Agreement may be executed in any number of counterparts, and each of such counterparts shall for all purposes be deemed to be an original, and all such counterparts, or as many of them as the parties shall preserve undestroyed, shall together constitute one and the same instrument**.**

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SIGNATURE PAGE

Third Amendment to the Agreement for Services of Independent Contractor between the **County of Santa Barbara** and **PathPoint**.

IN WITNESS WHEREOF, the parties have executed this Third Amendment to the Agreement to be effective as of the date executed by COUNTY.

COUNTY OF SANTA BARBARA:

By: _____
STEVE LAVAGNINO, CHAIR
BOARD OF SUPERVISORS

Date: _____

ATTEST:
MONA MIYASATO
COUNTY EXECUTIVE OFFICER
CLERK OF THE BOARD

By: _____
Deputy Clerk

Date: _____

CONTRACTOR:
PATHPOINT

By: Signed by: Harry Bruell 0BEA3DC498F54BB... _____
Authorized Representative

Name: Harry Bruell

Title: President/CEO

Date: 12/3/2024

APPROVED AS TO FORM:
RACHEL VAN MULLEM
COUNTY COUNSEL

By: Signed by: Bo Bae 4B3252DEFFD2466... _____
Deputy County Counsel

APPROVED AS TO ACCOUNTING FORM:
BETSY M. SCHAFFER, CPA
AUDITOR-CONTROLLER

By: DocuSigned by: 6BAAEA15901943F... _____
Deputy

RECOMMENDED FOR APPROVAL:
ANTONETTE NAVARRO, LMFT
DIRECTOR, DEPARTMENT OF
BEHAVIORAL WELLNESS

By: DocuSigned by: Antonette "Toni" Navarro 20B5C5A16FE1474... _____
Director

APPROVED AS TO FORM:
GREG MILLIGAN, ARM
RISK MANAGER

By: Signed by: Greg Milligan 05F555F00269466... _____
Risk Manager