Attachment B –
FSA FY 2023-27 (BC 23-125)
First Amendment, Executed

AMENDMENT TO MENTAL HEALTH SERVICES AGREEMENTS FOR CONTINGENCY PAYMENT, CONTINGENCY COST SETTLEMENT, MEDICARE PRACTITIONER BILLING AND FEE CHANGES

FIRST AMENDMENT TO THE

AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

THIS FIRST AMENDMENT to the Agreement for Services of Independent Contractor, **[BC # 23-125]**, is made by and between the **County of Santa Barbara** (County) and **Family Service Agency of Santa Barbara County** (Contractor) for the continued provision of services specified herein (hereafter First Amended Contract).

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, due to implementation of a new electronic health record system and delays related to claiming functionality, County and Contractor have determined the need to add contingency payment and contingency cost settlement provisions and to incorporate changes for Medicare practitioner billing and State rate changes with no change to the maximum contract amount set forth in Exhibit B.

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

I. Delete Subsection A (Fee-for-Service Rates) of Section III (Operating Budget and Fee for Services Rates) of Exhibit B Financial Provisions - MHS and replace it with the following:

A. Fee-For-Service Rates.

For Medi-Cal services, County agrees to reimburse Contractor at a Negotiated Fee-For-Service rate (the "Negotiated Fee") during the term of this Agreement as specified in Exhibit B-3 MHS. Specialty mental health services provided to Non-Medi-Cal clients will be paid at the same rates. Reimbursement or payment under this provision is subject to the maximum amount specified in the Exhibit B-1 MHS for Medi-Cal and Non-Medi-Cal specialty mental health services.

Notwithstanding the foregoing, and at any time during the term of the Agreement, the Director of the Department of Behavioral Wellness or designee, in his or her sole discretion, may incorporate new codes and make fee-for-service rate changes to Exhibit B-3 MHS issued by the California Department of Health Care Services and may make rate changes to Exhibit B-3 MHS for County's operational reasons. Additionally, the Behavioral Wellness Director or designee, in his or her sole discretion, may make rate changes to or otherwise update Exhibit B-3 MHS for multi-year contracts annually. Any changes to Exhibit B-3 MHS shall not alter the Maximum Contract Amount and shall not require an amendment to this Agreement but shall be in writing.

II. Delete Section VIII (Billing and Payment Procedures and Limitations) of Exhibit B Financial Provisions - MHS and replace it with the following:

VIII. BILLING AND PAYMENT PROCEDURES AND LIMITATIONS.

A. Submission of Claims and Invoices.

1. **Submission of Claims for Medi-Cal Services**. Services are to be entered into SmartCare based on timeframes prescribed in the Behavioral Wellness Clinical Documentation Manual. Late service data and claims may only be submitted in accordance with State and federal regulations. Behavioral Wellness shall provide to Contractor a report that: i) summarizes the Medi-Cal services approved to be claimed for the month, multiplied by the negotiated fee in effect at the time of service, ii) states the amount owed by County, and iii) includes the Agreement number.

   Contractor agrees that it shall be solely liable and responsible for all data and information submitted to the County and submitted by the County to the State on behalf of Contractor.

   If any services in the monthly Medi-Cal claim for the Contractor are denied by DHCS then these will be deducted from the subsequent monthly claim at the same value for which they were originally claimed.

2. **Submission of Claims for Medicare Services**

   i. **Provider Enrollment.** Contractors that provide service to clients that are eligible for both Medicare and Medi-Cal (AKA Medi-Medi) shall have Medicare eligible practitioner types enrolled in the Medicare program. The following are Medicare eligible licensed practitioners that provide service to County programs in this Agreement and must be enrolled in the Medicare program: Marriage and Family Therapist, Clinical Psychologist, Clinical Social Worker, Professional Clinical Counselor, Nurse Practitioner, Physician Assistant, and Medical Doctor. If any of the Contractor's eligible licensed practitioners have submitted a Medicare "Opt-Out" affidavit and are therefore opted-out of Medicare, these practitioners' services cannot be billed to Medicare and are not billable to Medi-Cal. *Opted-Out Medicare eligible practitioners are therefore ineligible service providers for Medi-Medi clients.*

   ii. **Medi-Medi.** The County won't assume financial responsibility or reimburse for services provided to Medi-Medi clients by ineligible service providers due to opting out of Medicare.

   iii. **Client Medicare Eligibility.** Contractor is responsible for identifying Medicare as a payor in the SmartCare EHR system. County only assumes financial responsibility for clients that are dual eligible for Medicare and Medi-Cal. Services provided to clients who have only Medicare, but not Medi-Cal are not eligible for reimbursement under this Agreement.

   iv. **Claims Adjudication.** For Medi-Medi client services, Contractor has the option to claim services to the Medicare fiscal intermediary directly or have the County process dual eligible claims on their behalf. If Contactor chooses to bill Medicare directly, Contractor is solely responsible to ensure proper Medicare registration and maintenance of such. Contractor shall notify Behavioral

Wellness Fiscal within 30 days of the beginning of the contract term whether they want County to bill Medicare on their behalf. If the Contractor opts to bill the Medicare fiscal intermediary directly then they shall provide the County with Medicare claim(s) adjudication data which would allow the County to submit a crossover claim to the State Department of Health Care Services for the Medi-Cal adjudication and payment. If Contractor opts to bill Medicare directly then the claims adjudication data would be due monthly to Behavioral Wellness within 15 days following the close of each month.

v. **Submission of Claims for Medicare Services.** For Medi-Medi client services, services are to be entered into the SmartCare EHR system based on timeframes prescribed in the Behavioral Wellness Clinical Documentation Manual. Late service data and claims may only be submitted in accordance with State and federal regulations. Contractor agrees that it shall be solely liable and responsible for all data and information submitted to the County and submitted by the County to the State on behalf of Contractor.

vi. **Claims Processing and Payment.**

Services provided to clients who are eligible for Medicare and Medi-Cal (Medi-Medi) will be claimed based on the guidelines outlined in the DHCS Billing Manual and Centers for Medicare & Medicaid Services (CMS) guidance. Contractor will be reimbursed for dual eligible clients at the Medi-Cal fee-for-service rates in the Exhibit B-3 consistent with the payment terms for Medi-Cal approved services. The Medicare payment received by the County will be reported to DHCS within the subsequent Medi-Cal claim, thereby reducing the charge to Medi-Cal by the paid Medicare amount. County will issue a single payment for the service, at the fee-for-service rate in Exhibit B-3. Alternatively, if Contractor bills Medicare directly, then the Medicare payment received by the contactor must be offset from the fee-for-service rates paid by the County or remitted to the County. Services for clients with Medicare coverage only (not Medi-Medi) shall not be entered into SmartCare EHR, nor processed or paid by County. The fee schedule in Exhibit B-3 is therefore not applicable for Medicare only clients. The Contractor is therefore solely responsible to follow all CMS regulations and provisions that govern Medicare beneficiary deductibles, co-pays and payments for services.

3. **Submission of Claims for Non Medi-Cal Programs**. Contractor shall submit a written invoice within 15 calendar days of the end of the month in which non-Medi-Cal services are delivered that: i) depicts the actual costs of providing the services less any applicable revenues, ii) states the amount owed by County, and iii) includes the Agreement number and signature of Contractor's authorized representative. Invoices shall be delivered to the designated representative or address described in Section VIII.A.1 (Submission of Claims for Medi-Cal Services) of this Exhibit B MHS. Actual cost is the actual amount paid or incurred, including direct labor and costs supported by financial statements, time records, invoices, and receipts.

4. **Timing of Payment.** The Program Contract Maximums specified in Exhibit B-1-MHS and this Exhibit B MHS are intended to cover services during the entire term of the Agreement, unless otherwise specified in the Exhibit A(s) to this Agreement (such as time-limited or services tied to the school year). Under no circumstances shall Contractor cease services prior to June 30 due to an accelerated draw down of

funds earlier in the Fiscal Year. Failure to provide services during the entire term of the Agreement may be considered a breach of contract and subject to the Termination provisions specified in the Agreement.

The Behavioral Wellness Director or designee shall review the monthly claim(s) and invoices to confirm accuracy of the data submitted. County shall make payment for approved Medi-Cal claims within thirty (30) calendar days of the generation of said claim(s) by County subject to the contractual limitations set forth in this Agreement and all exhibits hereto. Non-Medi-Cal programs will be paid within 30 days of the receipt of a complete invoice and all requested supporting documentation.

B. Monthly Financial Statements. For Non-Medi-Cal programs and costs, within 15 calendar days of the end of the month in which services are delivered, Contractor shall submit monthly financial statements reflecting the previous month's and cumulative year to date direct and indirect costs and other applicable revenues for Contractor's programs described in the Exhibit A(s).

C. Withholding of Payment for Non-submission of Service Data and Other Information. If any required service data, invoice, financial statement or report is not submitted by Contractor to County within the time limits described in this Agreement or if any such information is incomplete, incorrect, or is not completed in accordance with the requirements of this Agreement, then payment shall be withheld until County is in receipt of complete and correct data and such data has been reviewed and approved by Behavioral Wellness Director or designee. Behavioral Wellness Director or designee shall review such submitted service data within sixty (60) calendar days of receipt.

D. Withholding of Payment for Unsatisfactory Clinical Documentation. Behavioral Wellness Director or designee shall have the option to deny payment for services when documentation of clinical services does not meet minimum Federal, State and County written standards. County may also deny payment for services that are provided without a current client service plan when applicable authorities require a plan to be in place.

E. Claims Submission Restrictions.

1. 12-Month Billing Limit. Unless otherwise determined by State or federal regulations (e.g. Medi-Medi cross-over), all original (or initial) claims for eligible individual persons under this Agreement must be received by County within 12 months from the month of service to avoid denial for late billing.

2. No Payment for Services Provided Following Expiration/ Termination of Agreement. Contractor shall have no claim against County for payment of any funds or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment, it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provision shall survive the expiration or other termination of this Agreement.

F. Claims Certification and Program Integrity. Contractor shall certify that all services entered by Contractor into County's EHR for any payor sources covered by this Agreement are true and accurate to the best of Contractor's knowledge.

G. Overpayments. If the Contractor discovers an overpayment, Contractor must notify the County in writing of the reason for the overpayment. Any overpayments of contractual amounts must be returned via direct payment within 30 calendar days to the County after the date on which the overpayment was identified. County may withhold amounts from future payments due to Contractor under this Agreement or any subsequent agreement if Contractor fails to make direct payment within the required timeframe.

III. Add Section XI (Contingency Payment Provisions) to Exhibit B Financial Provisions - MHS as follows:

XI. CONTINGENCY PAYMENT PROVISIONS

A. Contingency Invoicing Plan (CIP)

If the SmartCare EHR system causes delays or challenges to the extent that services cannot be claimed (and paid to the provider) within 45 days of the service month-end, the County will activate the Contingency Invoicing Plan (CIP) outlined below:

1. **Notification and Submission**. Within 4 calendar days of determining that claiming will be delayed beyond the standard claiming window, the County will initiate the CIP and request the Contractor to electronically submit financial statements to FinanceCBO@sbcbwell.org.
2. **Review and Payment**. Upon receiving the financial statements, the County will review them. If found satisfactory, payment to the Contractor will be issued within 15 days. The payment will be calculated based on the lower of actual costs less applicable revenues or 1/12th of the Maximum Contract Allocation for Medi-Cal Patient Revenue on a cumulative year-to-date basis. If payment is based on actual costs, it will be further limited by the Medi-Cal penetration rate in the contract.
3. **Resolution and Adjustment**. If the EHR delays or challenges are resolved during the invoice processing period, payment will be based on the services claimed in the system instead of the CIP protocol. Any payments made under the CIP will be reconciled back to actual claimed services once the system claiming functionality is fully validated, and claiming issues are resolved.
4. **Monthly Determination**. The decision on whether to use the CIP will be made by the Director of the Department of Behavioral Wellness or designee in his or her sole discretion on a monthly basis, considering the prevailing circumstances.

B. Contingency Settlement

Notwithstanding any other provision of this Agreement, and applicable only to fiscal year 2023–2024 or July 1, 2023, through June 30, 2024, the Director of the Department of Behavioral Wellness or designee, in his or her sole discretion, may choose to reimburse Contractor on a cost reimbursement basis for Medi-Cal fee-for-service programs. Cost reimbursement is subject to the limitations described in this Agreement and all exhibits hereto and contingency on satisfactory performance of the services described in Exhibit A(s). This would be executed through a contingency settlement, subject to the program and total contract maximums outlined in Exhibit B MHS and B-1 MHS, and net of any revenues collected by the Contractor.

1. **Process.**

i. The Contractor shall notify the County within 60 days of fiscal year end that it has opted to be evaluated for a contingency settlement. By opting for the contingency settlement, Contractor must submit final fiscal year financial statements for the specified Medi-Cal programs that meet the guidelines identified in Section 4 below.

ii. The results of opting-in to this contingency settlement will be that following year end, the County will evaluate total Contractor financial statement costs (limited to contract maximums by program), and compare that to the total value of billed services under the fee-for-service provision. If the review determines that overall payment plus any incentives for which the Contractor qualifies for are lower than the actual allowed cost, County will enact an entity level contingency settlement that reimburses the Contractor up to the full cost of contracted Medi-Cal programs.

iii. If the contingency settlement is enacted and Contractor is reimbursed based on actual costs, incentive payments will not be issued, as any costs incurred in establishing these QA/UM activities will be allowed and reimbursed up to the amounts allowed per program in the current Exhibit B-1.

2. **Applicability.** In the case of a contingency settlement, the cost reimbursement methodology will be applied to all Medi-Cal fee-for-service programs covered by the Agreement.

3. **Funding.** As part of the contingency settlement process, the Director of the Department of Behavioral Wellness or designee may reallocate between contract allocations specified in Exhibit B-1.

4. **Financial Statements**. Contractor shall submit financial statements to substantiate costs incurred, along with any other requested documentation by the County to validate costs. Costs must be directly associated with the contracted program and/or reasonably allocable to the program, with indirect costs limited to 15% of direct costs. Adherence to federal cost principles outlined in 2 CFR Part 200 OMB Uniform Guidance is also required. Costs in excess of the 15% indirect rate or unallowable per 2 CFR Part 200 will not be reimbursed as part of the contingency settlement.

5. **Payment Terms.** County will issue payment for the settlement within 60 days from receipt of financial statements and any other documentation requested to substantiate program costs.

IV. **Effectiveness.** The terms and provisions set forth in this First Amended Agreement shall modify and supersede all inconsistent terms and provisions set forth in the original Agreement. The terms and provisions of the original Agreement, except as expressly modified and superseded by the First Amended Agreement, is 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.

V. **Execution of Counterparts.** This First 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 FOLLOWS

First Amendment to Agreement for Services of Independent Contractor between the **County of Santa Barbara** and **Family Service Agency of Santa Barbara County**.

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

COUNTY OF SANTA BARBARA:
ANTONETTE NAVARRO, LMFT, DIRECTOR
DEPARTMENT OF BEHAVIORAL WELLNESS

By: DocuSigned by: Antonette "Toni" Navarro
2095C5A16FE1474...

Date: 6/27/2024

CONTRACTOR:
FAMILY SERVICE AGENCY OF SANTA BARBARA COUNTY

By: DocuSigned by: Lisa Brabo
5658639A7B50479...
Authorized Representative

Name: Lisa Brabo

Title: Chief Executive Officer

Date: 6/27/2024

APPROVED AS TO FORM:
RACHEL VAN MULLEM
COUNTY COUNSEL

By: DocuSigned by: Teresa Martinez
23254F3F173540D...
Deputy County Counsel

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

By: DocuSigned by:
6BAAEA15901943F...
Deputy

APPROVED AS TO INSURANCE FORM:
GREG MILLIGAN, ARM
RISK MANAGEMENT

By: DocuSigned by: Greg Milligan
05F555F00269466...
Risk Management