Board Contract: 22-031

FIRST AMENDMENT TO THE AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

BETWEEN

COUNTY OF SANTA BARBARA
DEPARTMENT OF BEHAVIORAL WELLNESS

AND

TELECARE CORPORATION

FOR

MENTAL HEALTH SERVICES

FIRST AMENDMENT TO THE AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

THIS FIRST AMENDMENT to the Agreement for Services of Independent Contractor, referenced as BC 22-031, is made by and between the County of Santa Barbara (County), and **Telecare Corporation** (Contractor, for the continued provision of services specified herein (First 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;

WHEREAS, on June 28, 2022, the County Board of Supervisors authorized the Department of Behavioral Wellness to enter into an Agreement for Services of Independent Contractor, referred to as BC 22-031, for the provision of Adult Mental Health services for a total Maximum Contract Amount not to exceed **$11,846,000, inclusive of $5,923,000 per Fiscal Year, for the period of July 1, 2022 through June 30, 2024** (Agreement); and

WHEREAS, this First Amended Agreement updates the language in the Statement of Work for Santa Maria Adults/Older Adults Full Service Partnership services, adds flex funding for the Santa Maria Full Service Partnership in the amount of $100,000 for FY 23-24, adds client board and care in the amount of $20,000 to the Schedule of Rates and Contract Maximum, implements the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Payment Reform changes to the Agreement through the addition of a new Exhibit B-MHS (Financial Provisions) for FY 23-24, a new Exhibit B-2 (Entity Budget by Program) for FY 23-24, and Exhibit B-3 (Entity Rates and Codes by Service Type) for FY 23-24, updates Section II. Maximum Contract Amount in Exhibit B-MHS (Financial Provisions) for FY 22-23, increases the contract maximum amount for FY 22-23 by $196,167, and increases the FY 23-24 amount by $717,950, for a new contract maximum not to exceed **$12,760,117**, inclusive of **$6,119,167** for FY 22-23 and **$6,640,950** for FY 23-24, for the period of July 1, 2022 through June 30, 2024.

WHEREAS, due to the 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 the heading and section 1 (Program Summary) of <u>Exhibit A-3 Statement of Work: MHS Santa Maria ACT</u> and replace with the following heading and new section 1:**

EXHIBIT A-3

STATEMENT OF WORK: MHS

Santa Maria Adults/Older Adults Full-Service Partnership (FSP)

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1. **PROGRAM SUMMARY.** The Santa Maria Adults/Older Adults Full-Service Partnership (hereafter Program) shall provide individuals 18 years of age or older, 24 hours, 7 days a week, 365 days a year response and outpatient mental health services to individuals in mental health crisis. The Program shall deliver treatment, rehabilitative and supportive services to clients "in vivo" in regular community settings (e.g., home, apartment, job site) through a full-service partnership (FSP) model. Program clients have significant personal difficulties functioning in major life domains such as maintaining affordable, safe and stable housing, meaningful daily pursuits such as employment and job placement, as well as satisfying interpersonal relationships. The role of the FSP team is to address the rehabilitation needs of clients in these key domain areas so as to stabilize their housing and enhance their wellbeing. This Program requires a flexible approach to program delivery using a whatever-it-takes principle. The Program will be located at:

   A. 124 West Carmen Lane, Suite A, Santa Maria, California, 93458.

II. Delete section 7.C. (Graduate Student Interns/Trainees and Interns/Trainees) of Exhibit A-3 Statement of Work: MHS Santa Maria Adults/Older Adults Full-Service Partnership (FSP) and replace with the following:

C. Graduate Student Interns/Trainees and Interns/Trainees. Contractor may utilize interns or trainees as staff to provide services but only as is consistent with any and all applicable laws, regulations, and policies, as may be amended, and under direct supervision as specified in *Behavioral Wellness Policy and Procedure #8.400, Clinical Supervision of Pre-Licensed Providers.*

III. Add section 9.P. (Full Service Partnership (FSP) Service Requirements) to Exhibit A-3 Statement of Work: MHS Santa Maria Adults/Older Adults Full-Service Partnership (FSP), Section 9. Services as follows:

P. Full Service Partnership (FSP) Service Requirements.

1. Beneficiaries will be eighteen years or older and selected for participation in FSP Service Category must meet the following eligibility criteria:

   a. Transition age youth (persons ages 16 - 25 years of age) must:
      i. Meet criteria for an emotionally seriously disturbed disorder.
      ii. Be unserved or underserved and one of the following:
         1) Homeless or at risk of being homeless;
         2) Aging out of the child and youth mental health system;
         3) Aging out of the child welfare system;
         4) Aging out of the juvenile justice system;
         5) Involved in criminal justice system;
         6) At risk of involuntary hospitalization or institutionalization; or
         7) Have experienced a first episode of serious mental illness.

   b. Adults (persons 26 – 59 years of age) must meet criteria for a serious mental disorder and must meet one of the following:
      i. Be unserved and one of the following:

1) Homeless or at risk of becoming homeless;
2) Involved in the criminal justice system; or
3) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.

ii. Be underserved and at risk of one of the following:
1) Homelessness;
2) Involvement in the criminal justice system; or
3) Institutionalization.

c. Older adults (persons 60 years of age or older) must meet the criteria for a serious mental disorder and must meet one of the following:
i. Be unserved and one of the following:
1) Experiencing a reduction in personal and/or community functioning.
2) Homeless
3) At risk of becoming homeless.
4) At risk of becoming institutionalized.
5) At risk of out-of-home care.
6) At risk of becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.

ii. Or, underserved and at risk of one of the following:
1) Homelessness.
2) Institutionalization.
3) Nursing home or out-of-home care.
4) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
5) Involvement in the criminal justice system.

d. Contractor shall, when they have the capacity, provide beneficiaries, who have FSP agreements, with a full spectrum of community services, including but not limited to, the following mental health services and supports:

i. Mental health treatment, including alternative, culturally specific treatments;
ii. Peer support;
iii. Wellness centers;
iv. Alternative treatment and culturally specific treatment approaches;
v. Personal service coordination/case management to assist the beneficiary (and, when appropriate, the beneficiary's family) in accessing needed medical, educational, social, vocational, rehabilitative and/or other community services;
vi. Needs assessments;
vii. Individual Services and Supports Plan (ISSP), or Treatment Plan, development;
viii. Crisis intervention/stabilization services;
ix. Non-mental health services and supports, including but not limited to:
x. Food;
xi. Clothing;
xii. Housing, including, but not limited, to:
a) rent subsidies;

b) housing vouchers;
c) house payments;
d) residence in drug/alcohol rehabilitation programs and transitional and temporary housing;
e) Cost of health care treatment;
f) Cost of treatment of co-occurring conditions, such as substance abuse; and/or
g) Respite care.

IV. Delete section 10 (Documentation Requirements) of Exhibit A-3 Statement of Work: MHS Santa Maria Adults/Older Adults Full-Service Partnership (FSP) and replace with the following:

10. DOCUMENTATION REQUIREMENTS. Contractor shall complete the following for each client:

A. A diagnostic assessment that establishes the presence of a serious mental illness, providing a basis for the medical necessity of FSP-level services. The diagnostic assessment shall be completed by the FSP Team Psychiatrist or by another team member who is a properly licensed mental health professional within sixty (60) days of admission and shall be updated when there is a transition or change in level of care needed, or as clinically indicated by the FSP Team;

B. Enter partner/client data into the state's Data Collection and Reporting (DCR) system. This data includes the Partnership Assessment Form (PAF) at intake, Key Event Tracking (KETs) as needed, and Quarterly Reports (3Ms) completed every three months from admission date. A designated program staff will be assigned to enter all partner/client data into the state's DCR system as required within the designated time frames.

C. Client Problem List and Treatment Plan. Contractor shall complete an Assessment, Problem List, and Treatment Plan (or Treatment Plan Progress Note for targeted case management and peer support services) for each client receiving Program services in accordance with CalAIM requirements, applicable Behavioral Wellness Policies and Procedures, and the Behavioral Wellness Clinical Documentation Manual.

D. Full Service Partnership Agreement. Contractor shall enter into a full-service partnership agreement with each client served in the Program, and when appropriate, the Client's family.

V. Delete the header and introductory paragraph of Exhibit B Financial Provisions-MHS and replace them with the following:

EXHIBIT B – FY 22-23

FINANCIAL PROVISIONS- MHS

Effective July 1, 2022 – June 30, 2023

(Applicable to programs described in Exhibit A-2-A-4

(With attached Exhibit B-1 MHS, Schedule of Rates and Contract Maximum)

Notwithstanding any other provision of this Agreement, Contractor shall commence performance under this Exhibit B – FY 22-23 Financial Provisions – MHS on July 1, 2022, and end performance upon completion, but no later than June 30, 2023, unless otherwise directed by County or unless earlier terminated.

This Agreement provides for reimbursement for services up to the Maximum Contract Amount, reflected in Section II below and Exhibit B-1-MHS. For Medi-Cal and all other services provided under this Agreement, Contractor shall comply with all applicable requirements necessary for reimbursement in accordance with Welfare and Institutions Code (WIC) §§ 14705-14711, and all other applicable Federal, State and local laws, regulations, rules, manuals, policies, guidelines and directives.

VI. Delete Section II (Maximum Contract Amount) of Exhibit B Financial Provisions – MHS and replace it with the following:

II. MAXIMUM CONTRACT AMOUNT

The Maximum Contract Amount of this Agreement shall not exceed **$6,119,167** for FY 22-23 and shall consist of County, State, and/or Federal funds as shown in Exhibit B-1-MH and subject to the provisions in Section I (Payment for Services) of this Exhibit B. 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.

VII. Add a new Exhibit B - FY 23-24 Financial Provisions – MHS as follows:

EXHIBIT B – FY 23-24

FINANCIAL PROVISIONS- MHS

Effective July 1, 2023 – June 30, 2024

(Applicable to programs described in Exhibits A2-A4)

With attached *Exhibit B-1* MHS (Schedule of Rates and Contract Maximum), *Exhibit B-2* (Entity Budget by Program) and *Exhibit B-3* (Entity Rates and Codes by Service Type).

Notwithstanding any other provision of this Agreement, Contractor shall commence performance under this Exhibit B – FY 23-24 Financial Provisions – MHS on July 1, 2023, and end performance upon completion, but no later than June 30, 2024, unless otherwise directed by County or unless earlier terminated.

This Agreement provides for reimbursement for services up to the Maximum Contract Amount, reflected in Section II below and Exhibit B-1-MHS. For Medi-Cal and all other services provided under this Agreement, Contractor shall comply with all applicable requirements necessary for reimbursement in accordance with Welfare and Institutions Code (WIC) §§ 14705-14711, and all other applicable Federal, State and local laws, ordinances, regulations, rules, manuals, policies, guidelines and directives.

I. PAYMENT FOR SERVICES.

A. Performance of Services.

1. Medi-Cal Programs. For Medi-Cal specialty mental health programs, the County reimburses all eligible providers on a fee-for-service basis pursuant to a fee schedule. Eligible providers claim reimbursement for services using appropriate Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes. Exhibit B-3 MHS contains a rate for each Eligible Practitioner or Service Type and the relevant CPT®/HCPCS code.

2. Non-Medi-Cal Programs. For Non-Medi-Cal programs and costs, Contractor shall be compensated on a cost reimbursement basis, subject to the limitations described in this Agreement and all exhibits hereto, for deliverables as established in the Exhibit B(s) based on satisfactory performance of the services described in Exhibit A(s).

B. Medi-Cal Billable Services. The services provided by Contractor as described in Exhibit A(s), that are covered by the Medi-Cal program, will be paid based on the satisfactory performance of services and the fee schedule(s) as incorporated in Exhibit B-1 MHS of this Agreement.

C. Non-Medi-Cal Billable Services. County recognizes that some of the services provided by Contractor's Program(s), described in the Exhibit A(s), may not be reimbursable by Medi-Cal or may be delivered to ineligible clients. Such services may be reimbursed by other County, State, and Federal funds to the extent specified in Exhibit B-1-MHS and pursuant to Section I.E (Funding Sources) of this Exhibit B MHS. Funds for these services are included within the Maximum Contract Amount.

Specialty mental health services delivered to Non-Medi-Cal clients will be reimbursed at the same fee-for-service rates in the Exhibit B-3 MHS as for Medi-Cal clients, subject to the maximum amount specified in the Exhibit B-1 MHS. Due to the timing of claiming, payment for Non-Medi-Cal client services will not occur until fiscal year end after all claims have been submitted to the California Department of Health Care Services (DHCS) and the ineligible claims are identifiable.

When the entire program is not billable to Medi-Cal (i.e. Non-Medi-Cal Program), reimbursement will be on cost reimbursement basis subject to other limitations as established in Exhibit A(s) and B(s).

D. Limitations on Use of Funds Received Pursuant to this Agreement. Contractor shall use the funds provided by County exclusively for the purposes of performing the services described in Exhibit A(s) to this Agreement. For Contractor Programs that are funded with Federal funds other than fee-for-service Medi-Cal, expenses shall comply with the requirements established in Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards and all other applicable regulations. Violation of this provision or use of County funds for purposes other than those described in the Exhibit A(s) shall constitute a material breach of this Agreement.

E. Funding Sources. The Behavioral Wellness Director or designee may reallocate between funding sources with discretion, including to utilize and maximize any additional funding or Federal Financial Participation (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 this Agreement.

F. Beneficiary Liability for Payment.

1. Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments. (Cal. Code Regs., Title 9, § 1810.365 (a).)
2. Contractor shall not hold beneficiaries liable for debts in the event that County becomes insolvent; for costs of covered services for which the State does not pay County; for costs of covered services for which the State or County does not pay to Contractor; 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 beneficiary. (42 C.F.R. § 438.106 and Cal. Code Regs. Title 9, § 1810.365(c).)
3. Contractor shall not bill beneficiaries, for covered services, any amount greater than would be owed if the Contractor provided the services directly. (42 C.F.R. § 483.106(c).)

G. DHCS assumes no responsibility for the payment to Contractor for services used in the performance of this Agreement. County accepts sole responsibility for the payment of Contractors in the performance of this Agreement per the terms of this Agreement.

II. MAXIMUM CONTRACT AMOUNT.

The Maximum Contract Amount of this Agreement shall not exceed **$6,640,950,** for FY 23-24 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.

III. OPERATING BUDGET AND FEE FOR SERVICE RATES

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 the 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. Director and/or designee may update the Exhibit B-3 MHS annually for multi-year contracts and/or to incorporate new codes or rate changes issued by the State Department of Health Care Services. Rate changes may also be made for operational reasons at the discretion of the Director and/or designee. Modifications to the Exhibit B-3 do not alter the Maximum Contract Amount and do not require an amendment to this Agreement.

B. Operating Budget. For Non Medi-Cal Programs, Contractor shall provide County with an Operating Budget on a format acceptable to, or provided by County, based on

costs of net of revenues as described in this Exhibit B-MHS, Section VI (Accounting for Revenues). The approved Operating Budget shall be attached to this Agreement as Exhibit B-2. County may disallow any expenses in excess of the adopted operating budget. Contractor shall request, in advance, approval from County for any budgetary changes. Indirect costs are limited to 15% of direct costs for each program and must be allocated in accordance with a cost allocation plan that adheres with OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

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.

IV. CLIENT FLEXIBLE SUPPORT FUNDS.

For Medi-Cal FSP programs, Contractor will receive a funding allocation to provide clients with flexible support for costs including, but not limited to housing, items necessary for daily living, and therapeutical support. Contractor shall abide by requirements in the Behavioral Wellness Policy and Procedure #19.007 for client flexible support costs. Contractor shall maintain documentation to support client flexible support costs and submit financial statements to County monthly in accordance with Exhibit B MHS, Section VIII.B, (Monthly Financial Statements) below.

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

A. 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 and submitted via Smartsheets.

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 Quality Care Management (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. By the end of the fiscal year, all 12 monthly QA reports must be submitted to the County to receive the incentive payment.

iii. Contractor QA staff or their designee shall attend at least 4 out of 6 bi-monthly County Quality Improvement Committee (QIC) meetings each fiscal year. Attendance 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 practitioner based programs, 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 day 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.

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.

VI. ACCOUNTING FOR REVENUES.

A. Accounting for Revenues. Contractor shall comply with all County, State, and Federal requirements and procedures, including, but not limited to, those described in California Welfare and Institutions Code (WIC) Sections 5709, 5710 and 14710, relating to: (1) the determination and collection of patient/client fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP), (2) the eligibility of patients/clients for Medi-Cal, Medicare, private insurance, or other third party revenue, and (3) the collection, reporting and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. For Non-Medi-Cal programs, grants, and any other revenue, interest and return resulting from services/activities and/or funds paid by County to Contractor shall also be accounted for in the Operating Budget.

B. Internal Procedures. Contractor shall maintain internal financial controls which adequately ensure proper billing and collection procedures. Contractor shall pursue payment from all potential sources in sequential order, with Medi-Cal as payor of last resort. All fees paid by or on behalf of patients/clients receiving services under this Agreement shall be utilized by Contractor only for the delivery of service units specified

in the Exhibit A(s) to this Agreement.

VII. REALLOCATION OF PROGRAM FUNDING.

Funding is limited by program to the amount specified in Exhibit B-1-MHS. Contractor cannot move funding between programs without explicit approval by Behavioral Wellness Director or designee. Contractor shall make written application to Behavioral Wellness Director or designee, in advance and no later than April 1 of each Fiscal Year, to reallocate funds as outlined in Exhibit B-1-MHS between programs, for the purpose of meeting specific program needs or for providing continuity of care to its clients. Contractor's application shall include a narrative specifying the purpose of the request, the amount of said funds to be reallocated, and the sustaining impact of the reallocation as may be applicable to future years. The Behavioral Wellness Director's or designee decision of whether to allow the reallocation of funds shall be in writing to Contractor prior to implementation by Contractor. The Behavioral Wellness Director or designee also reserves the right to reallocate between programs in the year end settlement and will notify Contractor of any reallocation during the settlement process.

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.

   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.

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. **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.

iii. **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 of 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.

iv. **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.

v. **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.

IX. REPORTS.

A. **Audited Financial Reports.** Contractor is required to obtain an annual financial statement audit and submit to County a copy of their audited annual financial statement, including management comments. This report shall be submitted within thirty (30) days after the report is received by Contractor.

B. **Single Audit Report.** If Contractor is required to perform a single audit and/or program specific audit, per the requirements of OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements of Federal Awards, Contractor shall submit a copy of such single audit to County within thirty (30) days of receipt.

X. AUDITS AND AUDIT APPEALS.

A. **Audit by Responsible Auditing Party.** At any time during the term of this Agreement or after the expiration or termination of this Agreement, in accordance with State and Federal law, including, but not limited to, WIC Section 14170 et. seq., authorized

representatives from the County, State, or Federal governments (Responsible Auditing Party) may conduct an audit or site review of Contractor regarding the mental health services/activities provided under this Agreement.

B. **Settlement.** Settlement of the audit findings will be conducted according to the Responsible Auditing Party's procedures in place. In the case of a State Medi-Cal audit, the State and County will perform a post-audit Medi-Cal settlement that is based on State audit findings. Such settlement will take place when the State initiates its settlement action, which customarily is after the issuance of the audit report by the State and before the State's audit appeal process. However, if the Responsible Auditing Party stays its collection of any amounts due or payable because of the audit findings, County will also stay its settlement of the same amounts due or payable until the Responsible Auditing Party initiates its settlement action with County. If an audit adjustment is appealed, then the County may, at its own discretion, notify Contractor but stay collection of amounts due until resolution of the State administrative appeals process.

C. **Invoice for Amounts Due.** County shall issue an invoice to Contractor for any amount due to the County after the Responsible Auditing Party issues an audit report. The amount on the County invoice is due by Contractor to County thirty (30) calendar days from the date of the invoice.

D. **Appeal.** Contractor may appeal any such audit findings in accordance with the audit appeal process established by the Responsible Auditing Party performing the audit.

XII. 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

Not withstanding 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-1 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.. Reallocation of contract allocations does not require an amendment to the contract.
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.

IX. Delete Exhibit B-1 – MHS: Schedule of Rates and Contract Maximum applicable to FY 22-23 and FY 23-24 and replace it with the following:

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

CONTRACTOR NAME: Telecare Corporation **FISCAL YEAR:** 2022-2023

Contracted Services (1)	Service Type	Mode	Service Description	Unit of Service	Service Function Code	County Maximum Allowable Rate FY 22-23 (4)
Medi-Cal Billable Services	24-Hour Services	05	Adult Crisis Residential	Bed Day	40	$459.78
			Residential Other: Board and Care	N/A	60	Actual Cost
			Adult Residential	Bed Day	65	$224.26
	Outpatient Services	15	Targeted Case Management	Minutes	01	$2.69
			Collateral	Minutes	10	$3.47
			*MHS- Assessment	Minutes	30	$3.47
			*MHS - Plan Development	Minutes	31	$3.47
			(1) MHS- Therapy (Individual, Group)	Minutes	40, 50	$3.47
			MHS - Rehab (Individual, Group)	Minutes	41, 51	$3.47
			Medication Eval/Management-Psychiatrist	Minutes	60	$6.42
			Medication Support and Training	Minutes	61, 62	$6.42
			Crisis Intervention	Minutes	70	$5.17
Non-Medi-Cal Services	Support Services	60	Life Support: Board and Care	N/A	40	Actual Cost
			Client Flexible Support	N/A	72	Actual Cost
			Other Non Medi-Cal Client	N/A	78	Actual Cost

	PROGRAM					TOTAL
	Carmen Lane CRT	Agnes Avenue CRT	McMillan Ranch	Santa Maria ACT		
GROSS COST:	$ 1,931,513	$ 1,649,800	$ 975,350	$ 1,686,084		$ 6,242,747
CONTRACTOR:						
PATIENT FEES			$ 123,580			$ 123,580
CONTRIBUTIONS						$ -
OTHER (LIST):						$ -
TOTAL CONTRACTOR REVENUES						$ -
TOTAL CONTRACT PAYABLE FY 22-23:	**$ 1,931,513**	**$ 1,649,800**	**$ 851,770**	**$ 1,686,084**		**$ 6,119,167**
SOURCES OF FUNDING FOR MAXIMUM CONTRACT AMOUNT (2)						
MEDI-CAL (3)	$ 965,757	$ 824,900	$ 562,168	$ 1,247,702		$ 3,600,527
NON-MEDI-CAL						$ -
SUBSIDY	$ 965,757	$ 824,900	$ 289,602	$ 438,382		$ 2,518,640
OTHER (LIST):						$ -
TOTAL CONTRACT PAYABLE FY 22-23:	**$ 1,931,513**	**$ 1,649,800**	**$ 851,770**	**$ 1,686,084**	**$ -**	**$ 6,119,167**

CONTRACTOR SIGNATURE: DocuSigned by: Trisha Memuth, Sr VP CFO Telecare — 0000FD0B93304EB...

FISCAL SERVICES SIGNATURE: DocuSigned by: Christie Boyer — 96D40AB0C0AD408...

(1) Additional services may be provided if authorized by Director or designee in writing.

(2) 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. The Director or designee also reserves the right to reallocate between funding sources in the year end cost settlement. Reallocation of funding sources does not alter the Maximum Contract Amount and does not require an amendment to the contract.

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

(4) Director or designee may increase or remove the CMA based on operating needs. Modifications to the CMA do not alter the Maximum Contract Amount and do not require an amendment to the contract.

* MHS Assessment and MHS Therapy services may only be provided by licensed, registered or waivered Mental Health clinicians, or graduate student interns under direct supervision of a licensed, registered or waivered Mental Health clinician.

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

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

Contracted Service	Service Type	Provider Group	Practitioner Type	Full Time Equivalent Staffing	Rate (Avg. Direct Bill rate)	Medi-Cal Target	Medi-Cal Contract Allocation
Medi-Cal Billable Services	24-Hour Services	24-Hour Services	Adult Crisis Residential	n/a	$505.00	6,004	$3,032,020
			Adult Residential	n/a	$250.00	3,470	$867,423
	Outpatient Services Fee-For-Service	Prescriber	Psychiatrist/ Contracted Psychiatrist	0.00	$762.49	0	$0
			Physicians Assistant	0.00	$405.75	0	$0
			Nurse Practitioner (& Cert Nurse Spec.)	1.00	$448.87	707	$317,350
		Non-Prescriber	Registered Nurse	1.00	$366.54	707	$259,146
			Licensed Vocational Nurse	1.00	$201.89	707	$142,738
			Licensed Psychiatric Technician	0.00	$172.49	0	$0
		Behavioral Health Provider	Psychologist/ Pre-licensed Psychologist	0.00	$362.62	0	$0
			LPHA / Assoc. LPHA	1.00	$246.98	707	$174,612
			Certified Peer Recovery Specialist	1.50	$196.01	1,061	$207,969
			Rehabilitation Specialists & Other Qualified Providers	7.00	$186.21	4,950	$921,749
				12.50		18,313	$5,923,007

Contracted Service	Service Type	Program(s)	Reimbursement Method	Non-Medi-Cal Contract Allocation
Non-Medi-Cal Billable Services	Outpatient Non-Medi-Cal Services (1)	(2% for Santa Maria AOA-FSP and McMillan; 10% Carmen and Agnes CRTs)	Fee-For-Service	$361,023
	Board and Care - Indigent Clients (6)	McMillan Ranch	SSI Rate	$20,000
	Quality Assurance & Utilization Management (3)	All Programs at 4%	Incentive	$236,920
	Client Flexible Funds	Santa Maria AOA-FSP	Cost Reimbursement	$100,000
				$717,943

Total Contract Maximum $6,640,950

Contract Maximum by Program & Estimated Funding Sources							
	PROGRAM(S)						Total
Funding Sources (4)	Santa Maria AOA-FSP	McMillan Ranch	Agnes Avenue Crisis Residential Treatment	Carmen Lane Crisis Residential Treatment			
Medi-Cal Patient Revenue (5)	$ 2,023,564	$ 867,423	$ 1,409,959	$ 1,622,061			$ 5,923,007
MHSA QA / UM Incentive	$ 80,943	$ 34,697	$ 56,398	$ 64,882			$ 236,920
MHSA Non-Medi-Cal Services	$ 40,471	$ 17,348	$ 140,996	$ 162,207			$ 361,023
MHSA Board and Care	$ -	$ 20,000	$ -	$ -			$ 20,000
MHSA Client Flexible Support	$ -	$ -	$ -	$ -			$ 100,000
TOTAL CONTRACT PAYABLE FY 23-24:	$ 2,244,978	$ 939,468	$ 1,607,353	$ 1,849,150	$ -	$ -	$ 6,640,950

CONTRACTOR SIGNATURE: DocuSigned by: Trisha Nemuth, Sr VP CRT Telecare — 0000FD0B93304EB...

FISCAL SERVICES SIGNATURE: DocuSigned by: 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) 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 of the agreement for required deliverables.

(3) 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.

(4) 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.

(5) 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.

(6) The board and care allocation is intended to cover the costs of indigent clients at the SSI rate which is currently $1,324 per month. Rate may be adjusted in January 2024 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.

X. Delete Exhibit B-2 – Entity Budget by Program for FY 22-24 and replace it with the following:

Santa Barbara County Department of Behavioral Wellness
Contract Budget Packet
Entity Budget By Program

AGENCY NAME: Telecare
COUNTY FISCAL YEAR: FY22-23

LINE #	COLUMN # 1	2	3	4	5	6
	I. REVENUE SOURCES:	COUNTY BEHAVIORAL WELLNESS PROGRAMS TOTALS	Carmen Lane CRT	Agnes Avenue CRT	McMillan Ranch	Santa Maria ACT
1	Contributions	$ -				
2	Foundations/Trusts	$ -				
3	Miscellaneous Revenue	$ -				
4	Behavioral Wellness Funding	$ 6,119,167	$ 1,931,513	$ 1,649,800	$ 851,770	$ 1,686,084
5	Other Government Funding	$ -				
6	Total Other Revenue	$ 6,119,167	$ 1,931,513	$ 1,649,800	$ 851,770	$ 1,686,084
	II. Client and Third Party Revenues:					
7	Client Fees	-				
8	SSI	$ 123,580			$ 123,580	
9	Total Client and Third Party Revenues	$ 123,580	$ -	$ -	$ 123,580	$ -
10	GROSS PROGRAM REVENUE BUDGET	$ 6,242,747	$ 1,931,513	$ 1,649,800	$ 975,350	$ 1,686,084
	III. DIRECT COSTS	COUNTY BEHAVIORAL WELLNESS PROGRAMS TOTALS	Carmen Lane CRT	Agnes Avenue CRT	McMillan Ranch	Santa Maria ACT
	III.A. Salaries and Benefits Object Level					
11	Salaries (Complete Staffing Schedule)	$ 3,235,319	$ 986,660	$ 962,217	$ 426,405	$ 860,037
12	Employee Benefits	$ 571,463	$ 156,790	$ 116,796	$ 104,902	$ 192,975
13	Payroll Taxes	$ 257,748	$ 80,047	$ 71,767	$ 37,306	$ 68,627
14	Salaries and Benefits Subtotal	$ 4,064,530	$ 1,223,497	$ 1,150,781	$ 568,613	$ 1,121,639
	III.B Services and Supplies Object Level					
15	Mileage and Transportation	$ 69,541	$ 8,293	$ 2,700	$ 13,629	$44,919
16	Building Lease	$ 307,090	$ 85,500	$ 76,500	$ 83,043	$62,047
17	Depreciation	$ 51,437	$ 4,975	$ 4,759	$ 15,384	$26,318
18	Personnel Services	$ 124,887	$ 36,645	$ 32,632	$ 24,822	$30,789
19	Communications	$ 72,521	$ 12,834	$ 9,078	$ 12,404	$38,205
20	Insurance	$ 77,673	$ 21,918	$ 20,238	$ 15,208	$20,308
21	General & Adm	$ 135,986	$ 40,003	$ 22,044	$ 17,241	$56,699
22	Medical Supplies and services	$ 37,998	$ 8,188	$ 7,940	$ 15,457	$6,413
23	Physicial Plant	$ 93,080	$ 7,686	$ 4,899	$ 52,584	$27,911
24	Ancillary	$ 42	$ 42	$ -	$ -	$ -
25	Temporary Labor	$ 293,240	$ 193,537	$ 70,264	$ -	$ 29,439
26	Medical Records	$ 969	$ 382	$ 586	$ -	$ -
27	Services and Supplies Subtotal	$ 1,264,464	$ 420,005	$ 251,640	$ 249,772	$ 343,047
	III.C. Client Expense Object Level Total (Not Medi-Cal Reimbursable)	$ 99,488	$ 36,075	$ 32,188	$ 29,750	$ 1,474
28	Client Services -- Linen/Household Supplies, program expenses, dietary, member expenses	$ 99,488	$ 36,075	$ 32,188	$ 29,750	$ 1,474
29	SUBTOTAL DIRECT COSTS	$ 5,428,482	$ 1,679,577	$ 1,434,609	$ 848,136	$ 1,466,160
	IV. INDIRECT COSTS					
30	Administrative Indirect Costs (Reimbursement limited to 15%)	$ 814,265	$ 251,936	$ 215,191	$ 127,214	$ 219,924
31	GROSS DIRECT AND INDIRECT COSTS	$ 6,242,747	$ 1,931,513	$ 1,649,800	$ 975,350	$ 1,686,084

Add Exhibit B-3 – Entity Rates and Codes by Service Type for to FY 23-24 as follows:

EXHIBIT B-3

ENTITY RATES AND CODES BY SERVICE TYPE

PRESCRIBER FEES

Prescriber Fees

	Code	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate	Psychiatrist/ Contracted Psychiatrist	Physicians Assistant	Nurse Practitioner (& Nurse Specialist)
1	90785	Interactive Complexity	Supplemental Service Codes	Occurrence	$8.00	$8.00	$8.00
2	90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15	$190.62	$101.44	$112.22
3	90792	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	Assessment Codes	15	$190.62	$101.44	$112.22
4	90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27	$343.12	$182.59	$201.99
5	90833	Psychotherapy, 30 Minutes with Patient when Performed with an Evaluation and Management Service	Therapy Codes	27	$343.12	$182.59	$201.99
6	90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45	$571.87	$304.31	$336.65
7	90836	Psychotherapy, 45 Minutes with Patient when Performed with an Evaluation and Management Service	Therapy Codes	45	$571.87	$304.31	$336.65
8	90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60	$762.49	$405.75	$448.87
9	90838	Psychotherapy, 60 Minutes with Patient when Performed with an Evaluation and Management Service	Therapy Codes	60	$762.49	$405.75	$448.87
10	90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52	$660.82	$351.65	$389.02
11	90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30	$381.24	$202.87	$224.43
12	90845	Psychoanalysis, 15 Minutes	Therapy Codes	15	$190.62	$101.44	$112.22
13	90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50	$635.41	$338.12	$374.06
14	90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15	$190.62	$101.44	$112.22
15	90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15	$190.62	$101.44	$112.22
16	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	$190.62	$101.44	$112.22
17	90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15	$190.62	$101.44	$112.22
18	96161	Caregiver Assessment Administration of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15	$190.62	$101.44	$112.22
19	96365	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis, 1-60 Minutes	Medication Support Codes	46	$584.57	$311.07	$344.13
20	96366	Intravenous Infusion, for Therapy, Prophylaxis, Each Additional 30-60 Minutes past 96365	Medication Support Codes	45	$571.87	$304.31	$336.65
21	96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Additional Sequential Infusion, 1-60 Minutes after 96365	Medication Support Codes	31	$393.95	$209.64	$231.92
22	96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Concurrent Infusion, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
23	96369	Subcutaneous Infusion for Therapy or Prophylaxis, Initial, 15-60 Minutes	Medication Support Codes	36	$482.91	$256.97	$284.28
24	96370	Subcutaneous Infusion for Therapy or Prophylaxis, Each Additional 30-60 Minutes after 96369	Medication Support Codes	45	$571.87	$304.31	$336.65
25	96371	Subcutaneous Infusion for Therapy or Prophylaxis, Additional Pump Set-Up, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
26	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	$190.62	$101.44	$112.22
27	96373	Therapeutic, Prophylactic, or Diagnostic Injection; Intra- Arterial, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
28	96374	Therapeutic, Prophylactic, or Diagnostic Injection; Intravenous Push, Single or Initial Substance/Drug, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
29	96375	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Push of a New Substance/Drug, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
30	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	$190.62	$101.44	$112.22
31	96377	Application of On- body Injector for Timed Subcutaneous Injection, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
32	98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8		$54.10	$59.85
33	98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16		$108.20	$119.70
34	98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26		$175.82	$194.51
35	99202	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	Medication Support Codes	22	$279.58	$148.77	$164.59
36	99203	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	Medication Support Codes	37	$470.20	$250.21	$276.80
37	99204	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	Medication Support Codes	52	$660.82	$351.65	$389.02
38	99205	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	Medication Support Codes	67	$851.45	$453.08	$501.24
39	99212	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
40	99213	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	Medication Support Codes	25	$317.70	$169.06	$187.03
41	99214	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	Medication Support Codes	35	$444.79	$236.69	$261.84
42	99215	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	Medication Support Codes	47	$597.28	$317.83	$351.61
43	99242	Office Consultation for a New or Established Patient, Usually, the Presenting Problem(s) are of Low Severity, 21- 34 Minutes	Therapy Codes	25	$317.70	$169.06	$187.03
44	99243	Office Consultation for a New or Established Patient, Usually, the Presenting Problem(s) are of Moderate Severity, 35-49 Minutes	Therapy Codes	35	$444.79	$236.69	$261.84
45	99244	Office Consultation for a New or Established Patient, Usually, the Presenting Problem(s) are of Moderate to High Severity, 50-70 Minutes	Therapy Codes	47	$597.28	$317.83	$351.61
46	99245	Office Consultation for a New or Established Patient, Usually, the Presenting Problem(s) are of Moderate to High Severity, 71-90 Minutes	Therapy Codes	62	$787.90	$419.27	$463.83
47	99252	Inpatient Consultation for a New or Established Patient, Usually, the Presenting Problems(s) are of Low Severity, 30- 49 Minutes	Therapy Codes	40	$508.33	$270.50	$299.25
48	99253	Inpatient Consultation for a New or Established Patient, Usually, the Presenting Problems(s) are of Moderate Severity, 50-69 Minutes	Therapy Codes	52	$660.82	$351.65	$389.02
49	99254	Inpatient Consultation for a New or Established Patient, Usually, the Presenting Problems(s) are of Moderate to High Severity, 70-90 Minutes	Therapy Codes	70	$889.57	$473.37	$523.68
50	99255	Office Consultation for a New or Established Patient, Usually, the Presenting Problem(s) are of Moderate to High Severity, 91-130 Minutes	Therapy Codes	87	$1,105.61	$588.33	$650.86
51	99341	Home Visit of a New Patient, 15-25 Minutes	Medication Support Codes	22	$279.58	$148.77	$164.59
52	99342	Home Visit of a New Patient, 26-35 Minutes	Medication Support Codes	45	$571.87	$304.31	$336.65
53	99344	Home Visit of a New Patient, 51-65 Minutes	Medication Support Codes	67	$851.45	$453.08	$501.24
54	99345	Home Visit of a New Patient, 66-80 Minutes	Medication Support Codes	82	$1,042.07	$554.52	$613.45
55	99347	Home Visit of an Established Patient, 10-20 Minutes	Medication Support Codes	25	$317.70	$169.06	$187.03
56	99348	Home Visit of an Established Patient, 21-35 Minutes	Medication Support Codes	35	$444.79	$236.69	$261.84
57	99349	Home Visit of an Established Patient, 36-50 Minutes	Medication Support Codes	50	$635.41	$338.12	$374.06
58	99350	Home Visit of an Established Patient, 51-70 Minutes	Medication Support Codes	67	$851.45	$453.08	$501.24
59	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		$405.75	$448.87
60	99367	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician, Patient and/or Family not Present, 30 Minutes or More	Plan Development Codes	60	$762.49		

XI.

EXHIBIT B-3

ENTITY RATES AND CODES BY SERVICE TYPE

PRESCRIBER FEES

Continued

Prescriber Fees

	Code	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate	Psychiatrist/ Contracted Psychiatrist	Physician's Assistant	Nurse Practitioner (& Nurse Specialist)
		Family Not Present. 30 Minutes or More					
2	99441	Telephone Evaluation and Management Service, 5-10 Minutes	Assessment Codes	8	$101.67	$54.10	$59.85
3	99442	Telephone Evaluation and Management Service, 11-20 Minutes	Assessment Codes	16	$203.33	$108.20	$119.70
4	99443	Telephone Evaluation and Management Service, 21-30 Minutes	Assessment Codes	26	$330.41	$175.82	$194.51
5	99451	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Minutes	Referral Codes	17	$216.04		
6	99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60	$762.49	$405.75	$448.87
7	G2212	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
8	H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15		$101.44	$112.22
9	H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15		$101.44	$112.22
0	H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
1	H0034	Medication Training and Support, per 15 Minutes	Medication Support Codes	15	$190.62	$101.44	$112.22
2	H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15	$190.62	$101.44	$112.22
3	H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15	$190.62	$101.44	$112.22
4	H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15	$190.62	$101.44	$112.22
5	H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15	$190.62	$101.44	$112.22
6	H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15	$190.62	$101.44	$112.22
7	T1001	Nursing Assessment/Evaluation, 15 Minutes	Assessment Codes	15			$112.22
8	T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15	$22.50	$22.50	$22.50
9	T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15	$190.62	$101.44	$112.22

Provider type	Tax1	Tax2	Tax3	Tax4	Tax5	Tax6	Tax7	Tax8	Tax9	Tax10
Physician (including Psychiatrist)	202C	202D	202K	204C	204D	204E	204F	204R	207K	207L
	207N	207P	207Q	207R	207S	207T	207U	207V	207W	207X
	207Y	207Z	2080	2081	2082	2083	2084	2085	208C	208D
	208G	208M	208U	208V	2098	2086	2087	2088		
Nurse Practitioner	363L									
Certified Nurse Specialist	364S									
Physicians Assistant	363A									

EXHIBIT B-3

ENTITY RATES AND CODES BY SERVICE TYPE

PROVIDER FEES

Behavioral Health Provider Fees

	Code	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate	Psychologist/ Pre-licensed Psychologist	LPHA & LCSW	MHRS & Other Designated	Peer Recovery Specialist
1	90785	Interactive Complexity	Supplemental Service Codes	Occurrence	$8.00	$8.00	$8.00	$8.00
2	90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15	$90.66	$61.74		
3	90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27	$163.18	$111.14		
4	90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45	$271.97	$185.23		
5	90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60	$362.62	$246.98		
6	90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52	$314.27	$214.05		
7	90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30	$181.31	$123.49		
8	90845	Psychoanalysis, 15 Minutes	Therapy Codes	15	$90.66	$61.74		
9	90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50	$302.19	$205.81		
10	90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15	$90.66	$61.74		
11	90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15	$90.66	$61.74		
12	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	$90.66	$61.74		
13	90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15	$90.66	$61.74		
14	96105	Assessment of Aphasia, per Hour	Assessment Codes	60	$362.62			
15	96110	Developmental Screening, 15 Minutes	Assessment Codes	15	$90.66	$61.74		
16	96112	Developmental Testing, First Hour	Assessment Codes	60	$362.62			
17	96113	Developmental Testing, Each Additional 30 Minutes	Assessment Codes	30	$181.31			
18	96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60	$362.62	$246.98		
19	96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60	$362.62	$246.98		
20	96125	Standardized Cognitive Performance Testing, per Hour	Assessment Codes	60	$362.62			
21	96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15	$90.66	$61.74		
22	96130	Psychological Testing Evaluation, First Hour	Assessment Codes	60	$362.62			
23	96131	Psychological Testing Evaluation, Each Additional Hour	Assessment Codes	60	$362.62			
24	96132	Neuropsychological Testing Evaluation, First Hour	Assessment Codes	60	$362.62			
25	96133	Neuropsychological Testing Evaluation, Each Additional Hour	Assessment Codes	60	$362.62			
26	96136	Psychological or Neuropsychological Test Administration, First 30 Minutes	Assessment Codes	30	$181.31			
27	96137	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30	$181.31			
28	96146	Psychological or Neuropsychological Test Administration, 15 Minutes	Assessment Codes	15	$90.66			
29	96161	Caregiver Assessment Administratio n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15	$90.66	$61.74		
30	98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8	$48.35	$32.93		
31	98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16	$96.70	$65.86		
32	98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26	$157.14	$107.02		
33	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	$362.62	$246.98		
34	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	$362.62	$246.98		
35	99484	Care Management Services for Behavioral Health Conditions, Directed by Physician, At Least 20 Minutes	Plan Development Codes	60	$362.62	$246.98		
36	G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes (automatically added by SmartCare as appropriate)	Add-on Code	15	$90.66	$61.74		
37	H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Peer Support Services Codes	15				$49.00
38	H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15	$90.66	$61.74	$46.55	$49.00
39	H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15	$90.66	$61.74	$46.55	$49.00
40	H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15	$90.66	$61.74	$46.55	$49.00
41	H0038	Self-help/peer services per 15 minutes	Peer Support Services Codes	15				$49.00
42	H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15	$90.66	$61.74	$46.55	$49.00
43	H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15	$90.66	$61.74	$46.55	$49.00
44	H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15	$90.66	$61.74	$46.55	$49.00
45	H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15	$90.66	$61.74	$46.55	$49.00
46	H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15	$90.66	$61.74	$46.55	$49.00
47	T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15	$22.50	$22.50	$22.50	$22.50
48	T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15	$90.66	$61.74	$46.55	$49.00

Provider type	Tax1	Tax2	Tax3	Tax4	Tax5	Tax6	Tax7	Tax8	Tax9
Psychologist/ Pre-licensed Psychologist	102L	103G	103T						
LPHA	1012	101Y	102X	103K	106H	1714	222Q	225C	2256
LCSW	106E	1041							
Peer Recovery Specialist	175T								
Mental Health Rehab Specialist	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 - Other Designated MH staff that bill medical	171R	172V	3726	373H	374U	376J			

EXHIBIT B-3

ENTITY RATES AND CODES BY SERVICE TYPE

PROVIDER FEES (CONTINUED)

Non-Prescriber Fees

	Code	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate	RN	LVN	Licensed Psychiatric Technician
1	90785	Interactive Complexity	Supplemental Service Codes	Occurrence	$8.00	$8.00	$8.00
2	90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15			
3	96110	Developmental Screening, 15 Minutes	Assessment Codes	15	$91.64		
4	96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60	$366.54		
5	96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60	$366.54		
6	96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15	$91.64		
7	96138	Psychological or Neuropsychological Test Administration by Technician, First 30 Minutes	Assessment Codes	30			$86.25
8	96139	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30			$86.25
9	96161	Caregiver Assessment Administratio n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15	$91.64	$50.47	
10	96365	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis, 1-60 Minutes	Medication Support Codes	46	$281.02		
11	96366	Intravenous Infusion, for Therapy, Prophylaxis, Each Additional 30-60 Minutes past 96365	Medication Support Codes	45	$274.91		
12	96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Additional Sequential Infusion, 1-60 Minutes after 96365	Medication Support Codes	31	$189.38		
13	96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Concurrent Infusion, 15 Minutes	Medication Support Codes	15	$91.64		
14	96369	Subcutaneous Infusion for Therapy or Prophylaxis, Initial, 15-60 Minutes	Medication Support Codes	38	$232.14		
15	96370	Subcutaneous Infusion for Therapy or Prophylaxis, Each Additional 30-60 Minutes after 96369	Medication Support Codes	45	$274.91		
16	96371	Subcutaneous Infusion for Therapy or Prophylaxis, Additional Pump Set-Up, 15 Minutes	Medication Support Codes	15	$91.64		
17	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	$91.64		
18	96373	Therapeutic, Prophylactic, or Diagnostic Injection; Intra- Arterial, 15 Minutes	Medication Support Codes	15	$91.64		
19	96374	Therapeutic, Prophylactic, or Diagnostic Injection; Intravenous Push, Single or Initial Substance/Drug, 15 Minutes	Medication Support Codes	15	$91.64		
20	96375	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Push of a New Substance/Drug, 15 Minutes	Medication Support Codes	15	$91.64		
21	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	$91.64		
22	96377	Application of On- body Injector for Timed Subcutaneous Injection, 15 Minutes	Medication Support Codes	15	$91.64		
23	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	$366.54		
24	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	$366.54		
25	99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60	$366.54	$201.89	$172.49
26	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			
27	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			
28	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			
29	G2212	Prolonged Outpatient Service beyond the Maximum Time; Each Additional 15 Minutes (automatically added by SmartCare as appropriate)	Add-on Code	15	$91.64	$50.47	$43.12
30	H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15	$91.64	$50.47	$43.12
31	H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15	$91.64	$50.47	$43.12
32	H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15	$91.64	$50.47	$43.12
33	H0034	Medication Training and Support, per 15 Minutes	Medication Support Codes	15	$91.64	$50.47	$43.12
34	H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15	$91.64	$50.47	$43.12
35	H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15	$91.64	$50.47	$43.12
36	H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15	$91.64	$50.47	$43.12
37	H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15	$91.64	$50.47	$43.12
38	H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15	$91.64	$50.47	$43.12
39	T1001	Nursing Assessment/Evaluation, 15 Minutes	Assessment Codes	15	$91.64	$50.47	$43.12
40	T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15	$22.50	$22.50	$22.50
41	T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15	$91.64	$50.47	$43.12

Provider type	Tax1	Tax2	Tax3
Pharmacist	183S		
RN	163W	367S	376G
LVN	164W	164X	
Licensed Psychiatric Technician	106S	167G	374J

XII. 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 Agreement. The terms and provisions of the Agreement, except as expressly modified and superseded by this First Amended Agreement, 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.

XIII. 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

SIGNATURE PAGE

First Amended Agreement for Services of Independent Contractor between the **County of Santa Barbara** and **Telecare Corporation.**

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

COUNTY OF SANTA BARBARA:

By: _____
STEVE LAVAGNINO, CHAIR
BOARD OF SUPERVISORS

Date: 6-25-24

ATTEST:
MONA MIYASATO
COUNTY EXECUTIVE OFFICER
CLERK OF THE BOARD

By: _____
Deputy Clerk

Date: 6-25-24

CONTRACTOR:
TELECARE CORPORATION

By: DocuSigned by: Trisha Niemuth, Sr VP CFO Telecare
0000FD0B93304EB...
Authorized Representative

Name: Trisha Niemuth, Sr VP CFO Telecare

Title: SVP/CFO

Date: 6/13/2024

APPROVED AS TO FORM:
RACHEL VAN MULLEM
COUNTY COUNSEL

By: DocuSigned by: Bo Bae
48A252DEFFD3466...
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 Navarro
2095C5A16EE1474...
Director

APPROVED AS TO FORM:
GREG MILLIGAN, ARM
RISK MANAGER

By: DocuSigned by: Gregory Milligan
05F555F00260466...
Risk Manager