Board Contract: 22-008

FIRST AMENDMENT TO THE AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

Between

COUNTY OF SANTA BARBARA
DEPARTMENT OF BEHAVIORAL WELLNESS
AND

PATHPOINT

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 22-008, by and between the County of Santa Barbara (County), a political subdivision of the state of California, and **PathPoint** (Contractor), a California nonprofit public benefit corporation, wherein Contractor agrees to provide, and County agrees to accept, the 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 herein set forth;

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

WHEREAS, this First Amended Agreement updates the language in the Mental Health Services General Provisions; updates the language in the Statement of Work for Adult Housing Support Program; updates the language in the Statement of Work for Supported Community Services South; adds client expense funds for Full Service Partnerships; implements California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Payment Reform changes through the addition of a new Exhibit B-MHS (Financial Provisions) for FY 23-25, the update of Exhibit B-1-MHS (Schedule of Rates and Contract Maximum) for FY 22-23, the addition of a new Exhibit B-1-MHS (Schedule of Rates and Contract Maximum) for FY 23-25, the update of EXH B-2 for FY 22-23, and the addition of Exhibit B-3 (Entity Rates and Codes by Service Type) for FY 23-25; and adds $949,124 per fiscal year in Mental Health Services funding for FY 23-25, for a new total maximum contract amount not to exceed **$9,595,933**, inclusive of $2,565,895 for FY 22-23, $3,515,019 for FY 23-24, and $3,515,019 for FY 24-25, for the period of July 1, 2022 through June 30, 2025.

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

I. Delete section 4.A. (Reports-Staffing) of <u>Exhibit A-1 MHS General Provisions</u> and replace with the following:

4. REPORTS.

A. Staffing (applies to FY 22-23). Contractor shall submit quarterly staffing reports to County. These staffing reports shall be on a form acceptable to, or provided by, County and shall report actual staff hours worked by position and shall include the employees' names, licensure status, bilingual and bicultural capabilities, budgeted monthly salary, actual salary, hire date, and, if applicable, termination date. The staffing reports shall be received by County no later than 25 calendar days following the end of the quarter being reported.

II. Delete section 13.B.1. (Quality Assurance Requirements) of Exhibit A-1 MHS General Provisions in its entirety.

III. Delete section 17. (Additional Program Requirements) of Exhibit A-1 MHS General Provisions and replace with the following:

17. ADDITIONAL PROGRAM REQUIREMENTS.

A. Beneficiary Handbook. Contractor shall provide the County of Santa Barbara Beneficiary Handbook to each potential beneficiary and beneficiary in an approved method listed in the *Department of Behavioral Wellness' Policy and Procedures #4.008 Beneficiary Information Materials* when first receiving Specialty Mental Health Services and upon request. Contractor shall document the date and method of delivery to the beneficiary in the beneficiary's file. Contractor shall inform beneficiaries that information is available in alternate formats and how to access those formats. (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26, attachments 3, 4; Cal. Code Regs., tit. 9, § 1810.360(e); 42 C.F.R. § 438.10.)

B. Written Materials in English and Spanish. Contractor shall provide all written materials for beneficiaries and potential beneficiaries, including provider directories, County of Santa Barbara Beneficiary Handbook, appeal and grievance notices, denial and termination notices, and Santa Barbara County's mental health education materials, in English and Spanish as applicable. (42 C.F.R. § 438.10(d)(3).) Contractor shall maintain adequate supply of County-provided written materials and shall request additional written materials from County as needed.

C. Maintain Provider Directory. Contractor shall maintain a provider directory on its agency website listing licensed individuals employed by the provider to deliver [mental health] services; the provider directory must be updated at least monthly to include the following information:

1. Provider's name;
2. Provider's business address(es);
3. Telephone number(s);
4. Email address;
5. Website as appropriate;
6. Specialty in terms of training, experience and specialization, including board certification (if any);
7. Services/ modalities provided;
8. Whether the provider accepts new beneficiaries;
9. The provider's cultural capabilities;
10. The provider's linguistic capabilities;
11. Whether the provider's office has accommodations for people with physical disabilities;
12. Type of practitioner;

13. National Provider Identifier Number;

14. California License number and type of license; and

15. An indication of whether the provider has completed cultural competence training.

D. **Policy and Procedure #2.001.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #2.001 Network Adequacy Standards and Monitoring.*

E. **Policy and Procedure #3.000.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #3.000 Beneficiary Rights.*

F. **Policy and Procedure #3.004.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #3.004* on advance directives and the County's obligations for Physician Incentive Plans, as applicable.

G. **Policy and Procedure #4.000.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.000 Authorization of Outpatient Specialty Services.*

H. **Policy and Procedure #4.001.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.001 Authorization of Therapeutic Behavioral Services (TBS), applicable to providers providing children services.*

I. **Policy and Procedure #4.008.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.008 Beneficiary Information Materials.*

J. **Policy and Procedure #4.012.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #4.012 Contracted Provider Relations.*

K. **Policy and Procedure #4.014.** Contractor shall comply with Department of Behavioral Wellness' Policy and Procedures #4.014 Service Triage for Urgent and Emergency Conditions.

L. **Policy and Procedure #5.008.** Mandatory Trainings Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #5.008 Mandatory Training.*

M. **Policy and Procedure #8.100.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.100 Mental Health Client Assessment.*

N. **Policy and Procedure #8.101.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.101 Mental Health Client Treatment Plans.*

O. **Policy and Procedure #8.102.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #8.102 Mental Health Progress Notes.*

P. **Policy and Procedure #19.004.** Contractor shall comply with *Department of Behavioral Wellness' Policy and Procedures #19.004 MHSA Full Service Partnership (FSP) services applicable to providers providing FSP services.*

Q. **Accessibility.** Contractor shall ensure that it provides physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical

or mental disabilities. (42 C.F.R. § 438.206(b)(1) and (c)(3).)

R. **Hours of Operation.** Contractor shall maintain hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which Contractor offers services to non-Medi-Cal beneficiaries. If Contractor only offers services to Medi-Cal beneficiaries, maintain hours of operation which are comparable to the hours Contractor makes available for Medi-Cal services not covered by County or another Mental Health Plan.

S. **Access to Routine Appointments.** Contractor shall provide access to routine appointments (1st appointment within 10 business days). When not feasible, Contractor shall give the client the option to re-contact the County's Access team toll free at (888) 868-1649 and request another provider who may be able to serve the client within the 10-business day standard.

T. **Hold Harmless.** Contractor agrees to hold harmless the State and beneficiaries in the event the County cannot or does not pay for services performed by the Contractor pursuant to this Agreement.

U. **Client Service Plan.** Contractor shall complete a Client Service Plan and assessment for each client receiving Program services in accordance with the Behavioral Wellness Clinical Documentation Manual: https://content.civicplus.com/api/assets/b8fa0624-5c58-4cd5-974a-247cd784a787?cache=1800.

IV. Delete section 3.A. (Services) of Exhibit A-2, Statement of Work: MHS Adult Housing Support and replace with the following:

3. SERVICES. Contractor shall provide twenty-four (24) hour per day, seven (7) days per week psychiatric rehabilitation, residential care and room and board for clients placed at the Program as described in Section 7 (Referrals).

A. Contractor shall provide the following mental health services, as needed and indicated on the Client Service Plan (see Section 8 Documentation Requirements), to Program clients:

1. **Collateral.** Collateral means a service activity to a significant support person in a client's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the client's client plan, as defined in Title 9 CCR Section 1810.206. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the client, consultation, and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity.
    i. A significant support person is a person, in the opinion of the client or the person providing services, who has or could have a significant role in the successful outcome of treatment, including but not limited to parents of a client, legal guardians or legal representatives of a

client, a person living in the same household as the client, the client's spouse, and the relatives of the client, as defined in Title 9 CCR Section 1810.246.1.

2. **Crisis Intervention**. Crisis intervention means a service lasting less than 24 hours, to or on behalf of a client for a condition that requires a more timely response than a regularly scheduled visit, as defined in Title 9 CCR Section 1810.209. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348. Crisis intervention services may either be face-to-face or by telephone with the client or the client's significant support person and may be provided anywhere in the community.

3. **Plan Development.** Plan Development means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a client's progress.

4. **Rehabilitation.** A service activity that includes, but is not limited to, assistance, improving, maintaining, or restoring functional skills, daily living skills, social and leisure skills, grooming, and personal hygiene skills, meal preparation skills, obtaining support resources, and/or obtaining medication education, as defined in Title 9 CCR Section 1810.243.

5. **Targeted Case Management**. Targeted case management means services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services, as defined in Title 9 CCR Section 1810.249. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.

V. Delete the heading and section 1 (Program Summary) of <u>Exhibit A-4 Statement of Work: MHS Supportive Community Services South (Paths to Recovery) and replace</u> with the following:

EXHIBIT A-4
STATEMENT OF WORK: MHS
South Community Full-Service Partnership (FSP)

1. **PROGRAM SUMMARY.** The South Community 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 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 the wellbeing of the clients. This Program requires a flexible approach to program delivery using a whatever-it- takes principal. The Program will be located at:

A. 315 E. Haley St., Suite 102, Santa Barbara, California.

VI. Add section 3.O (Full Service Partnership (FSP) Service Requirements) to Exhibit A-4 Statement of Work: MHS Supportive Community Services South (Paths to Recovery) as follows:

O Full Service Partnership (FSP) Service Requirements.

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

1. Mental health treatment, including alternative, culturally specific treatments;
2. Peer support;
3. Wellness centers;
4. Alternative treatment and culturally specific treatment approaches;
5. 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;
6. Needs assessments;
7. Individual Services and Supports Plan (ISSP) or Treatment Plan, development;
8. Crisis intervention/stabilization services;
9. Non-mental health services and supports, including but not limited to:
   a. Food;
   b. Clothing;
   c. Housing, including but not limited to:
      i. rent subsidies;
      ii. housing vouchers;
      iii. house payments;
      iv. residence in drug/alcohol rehabilitation programs and transitional and temporary housing;
      v. Cost of health care treatment;
      vi. Cost of treatment of co-occurring conditions, such as substance abuse; and/or
      vii. Respite care.

VII. Delete section 10 (Admission Criteria) of Exhibit A-4 Statement of Work: MHS Supportive Community Services South and replace with the following:

10. **ADMISSION CRITERIA.** Clients selected for participation in the FSP service category shall be eighteen years of age and older and must meet the following eligibility criteria:
    A. Transition age youth (TAY) must:
        1. Meet criteria for an emotionally seriously disturbed disorder.
        2. Be unserved or underserved and one of the following:
            i. Homeless or at risk of being homeless;
            ii. Aging out of the child and youth mental health system;
            iii. Aging out of the child welfare system;
            iv. Aging out of the juvenile justice system;
            v. Involved in the criminal justice system;
            vi. At risk of involuntary hospitalization or institutionalization; or
            vii. Have experienced a first episode of serious mental illness.

    B. Adults must meet criteria for a serious mental disorder and must meet one of the following:
        1. Be unserved and one of the following:
            i. Homeless or at risk of becoming homeless;
            ii. Involved in the criminal justice system; or
            iii. Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
        2. Be unserved and at risk of one of the following;
            i. Homelessness;
            ii. Involvement in the criminal justice system; or
            iii. Institutionalization.

    C. Older adults must meet criteria for serious mental disorders and must meet one of the following criteria.
        1. Homelessness; or
        2. Institutionalization.

VIII. Delete section 14.D. (Interns/Trainees) of Exhibit A-4 Statement of Work: MHS Supportive Community Services South (Paths to Recovery) and replace with the following:

D. 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.

IX. Delete section 15 (Documentation Requirements) of Exhibit A-4 Statement of Work: MHS Supportive Community Services South (Paths to Recovery) and replace with the following:

15. **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.

X. Delete the header and introductory paragraph of <u>Exhibit B, Financial Provisions-MHS</u> and replace 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 other applicable Federal, State and local laws, regulations, rules, manuals, policies, guidelines and

directives.

XI. Add a new Exhibit B-MHS, Financial Provisions for FY 23-25 as follows:

EXHIBIT B – FY 23-25
FINANCIAL PROVISIONS- MHS
Effective July 1, 2023 – June 30, 2025

(Applicable to programs described in Exhibits A2-A4)

With attached *Exhibit B-1* MHS (Schedule of Rates and Contract Maximum) 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 23-25 Financial Provisions – MHS on July 1, 2023, and end performance upon completion, but no later than June 30, 2025, 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 other applicable Federal, State and local laws, 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 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 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 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., tit. 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. tit 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 **$9,595,933**, inclusive of $2,565,895 for FY 22-23, $3,515,019 for FY 23-24, and $3,515,019 for FY 24-25, for the period of July 1, 2022 through June 30, 2025, and 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 Exhibit B-3 MHS. Specialty mental health services provided to Non-Medi-Cal clients will be paid at the same rates, subject to the maximum amount specified in the Exhibit B-1 MHS.

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.

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 for client flexible support costs. Documentation must be kept on file to support costs and financial statements should be submitted monthly in accordance with Exhibit B MHS, Section VIII.B below.

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

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

1. QA deliverables include:

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

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

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

2. UM deliverables include:

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

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

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

3. 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.

2. 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.

3. 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. Delete Exhibit B-1 – MHS: Schedule of Rates and Contract Maximum and replace it with the following:

EXHIBIT B-1-MHS - FY 22-23
SCHEDULE OF RATES AND CONTRACT MAXIMUM
(Applicable to programs described in Exhibit A2-A4)

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

CONTRACTOR NAME: PathPoint **FISCAL YEAR:** 2022-2023

Contracted Services(1)	Service Type	Mode	Service Description	Unit of Service	Service Function Code	FY22-23 County Maximum Allowable Rate(4)
Medi-Cal Billable Services	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
			*MHS- Therapy (Individual)	Minutes	40	$ 3.47
			MHS - Rehab (Family, Individual, Group)	Minutes	12, 41, 50	$ 3.47
			Medication Support and Training	Minutes	61, 62	$ 6.42
			Crisis Intervention	Minutes	70	$ 5.17
Non-Medi-Cal Billable Services	Outreach Services	45	Community Client Services	N/A	20	N/A

	PROGRAM					TOTAL
	Supportive Community Services (Paths to Recovery)	Residential Support Services	Phoenix House Supportive Services	Mountain House Supportive Services		
GROSS COST:	$ 1,157,100	$ 139,487	$ 794,883	$ 821,628		$2,913,098
LESS REVENUES COLLECTED BY CONTRACTOR:						
PATIENT FEES			$ 160,229	$ 186,974		$ 347,203
CONTRIBUTIONS						$ -
OTHER (LIST):						$ -
TOTAL CONTRACTOR REVENUES	$ -	$ -	$ 160,229	$ 186,974		$347,203
MAXIMUM ANNUAL CONTRACT AMOUNT PAYABLE:	**$ 1,157,100**	**$ 139,487**	**$ 634,654**	**$ 634,654**	**$ -**	**$ 2,565,895**

SOURCES OF FUNDING FOR MAXIMUM ANNUAL CONTRACT AMOUNT (2)						
MEDI-CAL (3)	$ 1,041,390	$ 107,405	$ 571,189	$ 571,189		$ 2,291,172
NON-MEDI-CAL						$ -
SUBSIDY	$ 115,710	$ 32,082	$ 63,465	$ 63,465		$ 274,723
OTHER (LIST):						$ -
TOTAL CONTRACT AMOUNT PAYABLE FY 22-23	**$ 1,157,100**	**$ 139,487**	**$ 634,654**	**$ 634,654**		**$ 2,565,895**

CONTRACTOR SIGNATURE: DocuSigned by: Harry Brull 0BEA3DC498F54BB... FISCAL SERVICES SIGNATURE: DocuSigned by: Christie Boyer 96D40AB0C0AD408...

(1) Additional services may be provided if authorized by Director of the Department of Behavioral Wellness or designee in writing. The authorization of additional services does not alter the Maximum Contract Amount and does not require an amendment to this Agreement.
(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. Interns/Trainees who have graduated and are in the 90-day period prior to obtaining their associate number are eligible to provide assessment and therapy services if a Livescan is provided by the Contractor for the Intern/Trainee.

EXHIBIT B-1-MHS - FY 23-25
SCHEDULE OF RATES AND CONTRACT MAXIMUM
(Applicable to programs described in Exhibit A2-A4)

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

CONTRACTOR NAME: PathPoint

FISCAL YEAR: 2023-2025

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

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

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

Contract Maximum by Program & Estimated Funding Sources							
	PROGRAM(S)						Total
Funding Sources (5)	Supportive Community Services (Paths to Recovery)	Residential Support Services	Phoenix House Supportive Services	Mountain House Supportive Services			
Medi-Cal Patient Revenue (6)	$ 1,350,583	$ 174,464	$ 748,680	$ 873,461			$ 3,147,187
MHSA QA / UM Incentive	$ 54,023	$ 6,979	$ 29,947	$ 34,938			$ 125,887
MHSA Non-Medi-Cal Services	$ 27,012	$ 3,489	$ 14,974	$ 17,469			$ 62,944
MHSA Board and Care	$ -	$ -	$ 20,000	$ 20,000			$ 40,000
MHSA Client Flexible Support	$ 139,000	$ -	$ -	$ -			$ 139,000
TOTAL CONTRACT PAYABLE PER F	**$ 1,570,618**	**$ 184,932**	**$ 813,601**	**$ 945,868**	**$ -**	**$ -**	**$ 3,515,019**
TOTAL CONTRACT PAYABLE FY 23-	**$ 3,141,236**	**$ 369,864**	**$ 1,627,202**	**$ 1,891,736**	**$ -**	**$ -**	**$ 7,030,038**

CONTRACTOR SIGNATURE: DocuSigned by: Harry Brull 0BEA3DC198F54BB...

FISCAL SERVICES SIGNATURE: DocuSigned by: Christie Boyer 96D40AB0C0AD108...

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

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

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

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

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

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

XIII. Delete Exhibit B-2 – Entity Budget by Program and replace it with the following:

EXHIBIT B-2

ENTITY BUDGET BY PROGRAM

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

AGENCY NAME: PathPoint
COUNTY FISCAL YEAR: Applies to FY 2022-2023 Only

LINE #	COLUMN # 1	2	3	4	5	6
	I. REVENUE SOURCES:	COUNTY BEHAVIORAL WELLNESS PROGRAMS TOTALS	Residential Supportive Services (RSS)	Suportive Community Services (Formerly PTR)	Phoenix House Supportive Services (PHSS)	Mountain House Supportive Services (MHSS)
1	Contributions	$ -				
2	Foundations/Trusts	$ -				
3	Miscellaneous Revenue	$ -				
4	Behavioral Wellness Funding	$ 2,565,895	$ 139,487	$ 1,157,100	$ 634,654	$ 634,654
5	Other Government Funding	$ -				
10	Total Other Revenue	$ 2,565,895	$ 139,487	$ 1,157,100	$ 634,654	$ 634,654
	II. Client and Third Party Revenues:					
11	Client Fees	-				
12	SSI	347,203			$ 160,229	$ 186,974
13	Other (specify)	-				
14	Total Client and Third Party Revenues	$ 347,203	$ -	$ -	$ 160,229	$ 186,974
15	GROSS PROGRAM REVENUE BUDGET	$ 2,913,098	$ 139,487	$ 1,157,100	$ 794,883	$ 821,628

	III. DIRECT COSTS	COUNTY BEHAVIORAL WELLNESS PROGRAMS TOTALS	Residential Supportive Services (RSS)	Suportive Community Services (Formerly PTR)	Phoenix House Supportive Services (PHSS)	Mountain House Supportive Services (MHSS)
	III.A. Salaries and Benefits Object Level					
16	Salaries (Complete Staffing Schedule)	$ 1,555,206	$ 94,879	$ 623,996	$ 421,246	$ 415,085
17	Employee Benefits	$ 180,217	$ 11,238	$ 81,962	$ 43,034	$ 43,982
18	Payroll Taxes & Work Comp	$ 160,442	$ 8,411	$ 55,317	$ 48,713	$ 48,000
19	Contract Employees	$ 130,000	$ -	$ 130,000	$ -	$ -
20	Residential Program Salaries & Benefits	$ 79,383	$ -		$ 39,692	$ 39,692
21	Salaries and Benefits Subtotal	$ 2,105,248	$ 114,529	$ 891,276	$ 552,685	$ 546,759
	III.B Services and Supplies Object Level					
22	Equipment Rental/Maintenance	$ 1,061	$ 124	$ 149	$ 394	$ 394
23	Equipment Purchase	$ 7,875	$ -	$ 5,250	$ 1,313	$ 1,313
24	Computer Maintenance	$ 1,676	$ 182	$ 293	$ 601	$ 601
25	Vehicle Expense	$ 29,400	$ -	$ 23,100	$ 3,150	$ 3,150
26	Use Allowance	$ 46,374	$ 289	$ 45,508	$ 289	$ 289
27	Facility Maintenance	$ 1,103	$ -	$ 1,103	$ -	$ -
28	Janitorial	$ 2,003	$ -	$ 1,638	$ 183	$ 183
29	Communications	$ 38,167	$ 3,054	$ 13,017	$ 11,048	$ 11,048
30	Office Supplies	$ 7,487	$ 626	$ 5,532	$ 665	$ 665
31	Program/Household Supplies	$ 5,166	$ 210	$ 739	$ 2,109	$ 2,107
32	Insurance	$ 16,157	$ 160	$ 1,680	$ 4,158	$ 10,159
33	Payroll Processing	$ 6,939	$ 460	$ 1,791	$ 2,372	$ 2,316
34	Depreciation	$ 16,460	$ 78	$ 1,883	$ 7,249	$ 7,250
35	Mileage	$ 7,177	$ 167	$ 5,670	$ 670	$ 670
36	Staff/Participant Training	$ 3,600	$ 296	$ 1,394	$ 964	$ 946
37	Membership Dues	$ 6,334	$ 827	$ 1,943	$ 1,782	$ 1,782
38	Printing/Publications	$ 1,508	$ 45	$ 1,095	$ 184	$ 184
39	Licensing	$ 2,310	$ -	$ 1,260	$ 525	$ 525
40	Personnel Recruitment	$ 3,025	$ 248	$ 772	$ 1,003	$ 1,003
41	Bank Charges	$ 32	$ -	$ 32	$ -	$ -
42	Consultants	$ 1,050	$ -	$ 1,050	$ -	$ -
43	Subscriptions	$ 445	$ -	$ -	$ 223	$ 223
44	Residential Program Services & Supplies	$ 222,533	$ -	$ -	$ 99,638	$ 122,895
45	Services and Supplies Subtotal	$ 427,880	$ 6,765	$ 114,898	$ 138,518	$ 167,700
	III.C. Client Expense Object Level Total (Not Medi-Cal Reimbursable)	$ -	$ -	$ -	$ -	$ -
46		$ -				
48	SUBTOTAL DIRECT COSTS	$ 2,533,129	$ 121,293	$ 1,006,174	$ 691,203	$ 714,459
	IV. INDIRECT COSTS					
49	Administrative Indirect Costs (Reimbursement limited to 15%)	$ 379,969	$ 18,194	$ 150,926	$ 103,680	$ 107,169
50	GROSS DIRECT AND INDIRECT COSTS	$ 2,913,098	$ 139,487	$ 1,157,100	$ 794,883	$ 821,628

XIV. Add Exhibit B-3 – Entity Rates and Codes by Service Type as follows:

EXHIBIT B-3 for FY 23-25
ENTITY RATES AND CODES BY SERVICE TYPE
Effective July 1, 2023 – June 30, 2025

Behavioral Health Provider Fees
FY 23-24 and 24-25

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
90785	Interactive Complexity	Supplemental Service Codes	Occurrence	$8.00	$8.00	$8.00	$8.00
90791	Psychiatric Diagnostic Evaluation, 15 Minutes	Assessment Codes	15	$72.52	$49.40		
90832	Psychotherapy, 30 Minutes with Patient	Therapy Codes	27	$130.54	$88.91		
90834	Psychotherapy, 45 Minutes with Patient	Therapy Codes	45	$217.57	$148.19		
90837	Psychotherapy, 60 Minutes with Patient	Therapy Codes	60	$290.10	$197.58		
90839	Psychotherapy for Crisis, First 30-74 Minutes 84	Crisis Intervention Codes	52	$251.42	$171.24		
90840	Psychotherapy for Crisis, Each Additional 30 Minutes	Crisis Intervention Codes	30	$145.05	$98.79		
90845	Psychoanalysis, 15 Minutes	Therapy Codes	15	$72.52	$49.40		
90847	Family Psychotherapy [Conjoint Psychotherapy] (with Patient Present), 50 Minutes	Therapy Codes	50	$241.75	$164.65		
90849	Multiple-Family Group Psychotherapy, 15 Minutes	Therapy Codes	15	$72.52	$49.40		
90853	Group Psychotherapy (Other Than of a Multiple-Family Group), 15 Minutes	Therapy Codes	15	$72.52	$49.40		
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	$72.52	$49.40		
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15	$72.52	$49.40		
96105	Assessment of Aphasia, per Hour	Assessment Codes	60	$290.10			
96110	Developmental Screening, 15 Minutes	Assessment Codes	15	$72.52	$49.40		
96112	Developmental Testing, First Hour	Assessment Codes	60	$290.10			
96113	Developmental Testing, Each Additional 30 Minutes	Assessment Codes	30	$145.05			
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60	$290.10	$197.58		
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60	$290.10	$197.58		
96125	Standardized Cognitive Performance Testing, per Hour	Assessment Codes	60	$290.10			
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15	$72.52	$49.40		
96130	Psychological Testing Evaluation, First Hour	Assessment Codes	60	$290.10			
96131	Psychological Testing Evaluation, Each Additional Hour	Assessment Codes	60	$290.10			
96132	Neuropsychological Testing Evaluation, First Hour	Assessment Codes	60	$290.10			
96133	Neuropsychological Testing Evaluation, Each Additional Hour	Assessment Codes	60	$290.10			
96136	Psychological or Neuropsychological Test Administration, First 30 Minutes	Assessment Codes	30	$145.05			
96137	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30	$145.05			
96146	Psychological or Neuropsychological Test Administration, 15 Minutes	Assessment Codes	15	$72.52			
96161	Caregiver Assessment Administratio n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15	$72.52	$49.40		
98966	Telephone Assessment and Management Service, 5-10 Minutes	Assessment Codes	8	$38.68	$26.34		
98967	Telephone Assessment and Management Service, 11-20 Minutes	Assessment Codes	16	$77.36	$52.69		
98968	Telephone Assessment and Management Service, 21-30 Minutes	Assessment Codes	26	$125.71	$85.62		
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	$290.10	$197.58		
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	$290.10	$197.58		
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60	$290.10	$197.58		
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Peer Support Services Codes	15				$39.20
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15	$72.52	$49.40	$37.24	$39.20
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15	$72.52	$49.40	$37.24	$39.20
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15	$72.52	$49.40	$37.24	$39.20
H0038	Self-help/peer services per 15 minutes	Peer Support Services Codes	15				$39.20
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15	$72.52	$49.40	$37.24	$39.20
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15	$72.52	$49.40	$37.24	$39.20
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15	$72.52	$49.40	$37.24	$39.20
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15	$72.52	$49.40	$37.24	$39.20
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15	$72.52	$49.40	$37.24	$39.20
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15	$72.52	$49.40	$37.24	$39.20
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15	$72.52	$49.40	$37.24	$39.20

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			

Non-Prescriber Fees
FY 23-24 and FY 24-25

Code	Code Description	Code Type	Time Associated with Code (Mins) for Purposes of Rate	RN	LVN	Licensed Psychiatric Technician
90785	Interactive Complexity	Supplemental Service Codes	Occurrence	$8.00	$8.00	$8.00
90887	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	Supplemental Service Codes	15			
96110	Developmental Screening, 15 Minutes	Assessment Codes	15	$73.31		
96116	Neurobehavioral Status Exam, First Hour	Assessment Codes	60	$293.23		
96121	Neurobehavioral Status Exam, Each Additional Hour	Assessment Codes	60	$293.23		
96127	Brief Emotional/Behavioral Assessment, 15 Minutes	Assessment Codes	15	$73.31		
96138	Psychological or Neuropsychological Test Administration by Technician, First 30 Minutes	Assessment Codes	30			$69.00
96139	Psychological or Neuropsychological Test Administration, Each Additional 30 Minutes	Assessment Codes	30			$69.00
96161	Caregiver Assessment Administratio n of Care- Giver Focused Risk Assessment, 15 Minutes	Supplemental Service Codes	15	$73.31	$40.38	
96365	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis, 1-60 Minutes	Medication Support Codes	46	$224.81		
96366	Intravenous Infusion, for Therapy, Prophylaxis, Each Additional 30-60 Minutes past 96365	Medication Support Codes	45	$219.93		
96367	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Additional Sequential Infusion, 1-60 Minutes after 96365	Medication Support Codes	31	$151.50		
96368	Intravenous Infusion, for Therapy, Prophylaxis, or Diagnosis; Concurrent Infusion, 15 Minutes	Medication Support Codes	15	$73.31		
96369	Subcutaneous Infusion for Therapy or Prophylaxis, Initial, 15-60 Minutes	Medication Support Codes	38	$185.72		
96370	Subcutaneous Infusion for Therapy or Prophylaxis, Each Additional 30-60 Minutes after 96369	Medication Support Codes	45	$219.93		
96371	Subcutaneous Infusion for Therapy or Prophylaxis, Additional Pump Set-Up, 15 Minutes	Medication Support Codes	15	$73.31		
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	$73.31		
96373	Therapeutic, Prophylactic, or Diagnostic Injection; Intra- Arterial, 15 Minutes	Medication Support Codes	15	$73.31		
96374	Therapeutic, Prophylactic, or Diagnostic Injection; Intravenous Push, Single or Initial Substance/Drug, 15 Minutes	Medication Support Codes	15	$73.31		
96375	Therapeutic, Prophylactic, or Diagnostic Injection; Each Additional Sequential Intravenous Push of a New Substance/Drug, 15 Minutes	Medication Support Codes	15	$73.31		
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	$73.31		
96377	Application of On- body Injector for Timed Subcutaneous Injection, 15 Minutes	Medication Support Codes	15	$73.31		
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	$293.23		
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	$293.23		
99484	Care Management Services for Behavioral Health Conditions, Directed by Physician. At Least 20 Minutes	Plan Development Codes	60	$293.23	$161.51	$137.99
99605	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with New Patient with Assessment and Intervention, 15 Minutes	Medication Support Codes	15			
99606	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with Established Patient with Assessment and Intervention, 15 Minutes	Medication Support Codes	15			
99607	Medication Therapy Management Service(s) Provided by a Pharmacist, Individual, Face-to- Face with Patient with Assessment and Intervention, each Additional 15 Minutes beyond 99605 or 99606.	Medication Support Codes	15			
H0031	Mental Health Assessment by Non- Physician, 15 Minutes	Assessment Codes	15	$73.31	$40.38	$34.50
H0032	Mental Health Service Plan Developed by Non-Physician, 15 Minutes	Plan Development Codes	15	$73.31	$40.38	$34.50
H0033	Oral Medication Administration, Direct Observation, 15 Minutes	Medication Support Codes	15	$73.31	$40.38	$34.50
H0034	Medication Training and Support, per 15 Minutes	Medication Support Codes	15	$73.31	$40.38	$34.50
H2000	Comprehensive Multidisciplinary Evaluation, 15 Minutes	Assessment Codes	15	$73.31	$40.38	$34.50
H2011	Crisis Intervention Service, per 15 Minutes	Crisis Intervention Codes	15	$73.31	$40.38	$34.50
H2017	Psychosocial Rehabilitation, per 15 Minutes	Rehabilitation Codes	15	$73.31	$40.38	$34.50
H2019	Therapeutic Behavioral Services, per 15 Minutes	Therapeutic Behavioral Services	15	$73.31	$40.38	$34.50
H2021	Community-Based Wrap-Around Services, per 15 Minutes 129	Rehabilitation Codes	15	$73.31	$40.38	$34.50
T1001	Nursing Assessment/Evaluation, 15 Minutes	Assessment Codes	15	$73.31	$40.38	$34.50
T1013	Sign Language or Oral Interpretive Services, 15 Minutes	Supplemental Service Codes	15	$73.31	$40.38	$34.50
T1017	Targeted Case Management, Each 15 Minutes	Referral Codes	15	$73.31	$40.38	$34.50

Provider type	Tax1	Tax2	Tax3
Pharmacist	1835		
RN	163W	3675	376G
LVN	164W	164X	
Licensed Psychiatric Technician	106S	167G	3747

XV. 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.

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

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

COUNTY OF SANTA BARBARA:

By: _____
DAS WILLIAMS, CHAIR
BOARD OF SUPERVISORS

Date: _____

ATTEST:
MONA MIYASATO
COUNTY EXECUTIVE OFFICER
CLERK OF THE BOARD

By: _____
Deputy Clerk

Date: _____

CONTRACTOR:
PATHPOINT

By: DocuSigned by: Harry Bruell 0BEA3DC498F54BB...
Authorized Representative

Name: Harry Bruell

Title: President/CEO

Date: 10/5/2023

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 2095C5A16FE1474...
Director

APPROVED AS TO FORM:
GREG MILLIGAN, ARM
RISK MANAGER

By: DocuSigned by: Gregory Milligan 05F555F00269466...
Risk Manager