FIRST AMENDMENT TO
TULARE COUNTY AGREEMENT NO 29323

THIS FIRST AMENDMENT ("Amendment") to Tulare County Agreement Number 29323 (the "Agreement") is entered into by and between the **COUNTY OF TULARE** ("COUNTY") and **COURAGE TO CHANGE** ("CONTRACTOR") as of July 1, 2019, with reference to the following:

A. The COUNTY and CONTRACTOR entered into the Agreement on July 1, 2019, for the purpose of providing specialty mental health services to Tulare County adolescent males.

B. COUNTY and CONTRACTOR now wish to amend the Agreement in order to include Exhibit A-1 Tulare County Mental Health Plan Quality Management Standards, Exhibit B-1 Compensation, and Exhibit B-3 Electronic Health Records Compensation for Fiscal Year 2019/2020

ACCORDINGLY, COUNTY and CONTRACTOR agree as follows:

1. Section II-Services of the Agreement is hereby revised to read as follows:
SERVICES: See attached Exhibit A-1

2. Section III-Payment for Services is hereby revised to read as follows:
PAYMENT FOR SERVICES: See attached Exhibits B-1, B-3

3. This First Amendment becomes effective as of July 1, 2019.

4. Except as provided above, all other terms and conditions of the Agreement shall remain in full force and effect.

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[FIRST] AMENDMENT TO
TULARE COUNTY AGREEMENT NO. 29323

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

COURAGE TO CHANGE

Date 3-19-20

By _____

Print Name Susan Gambini

Title Administrator

Date 3-19-20

By _____

Print Name Susan Gambini

Title Board of Director

[Pursuant to Corporations Code section 313, County policy requires that contracts with a Corporation be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a Limited Liability Company be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

COUNTY OF TULARE

Date _____

By _____
Chairman, Board of Supervisors

ATTEST: JASON T. BRITT
County Administrative Officer/Clerk of the Board
of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form:
County Counsel

By Eric Scott
Deputy

Matter # 2020314

ATTACHMENT A-1

TULARE COUNTY MENTAL HEALTH PLAN,

QUALITY MANAGEMENT STANDARDS

The Tulare County Alcohol, Drug and Mental Health Services Department is Tulare County's Medi-Cal Mental Health Plan (MHP) and has established standards for all organizational, individual, and group providers furnishing Specialty Mental Health Services. CONTRACTOR shall adhere to all current MHP policies and procedures (P&P's) in addition to the following standards. In the event of conflicting requirements, current P&P's will supersede the below standards. P&P's may be updated from time to time, and when an update occurs COUNTY shall notify CONTRACTOR and provide the revised P&P's. Copies of all current P&P's are available by contacting the Tulare County Mental Health Managed Care/QI division at (559) 624-8000.

1. Assessment

    A. Assessments shall be completed and/or updated in order to provide support for determinations of Medical Necessity for Specialty Mental Health Services (SMHS). Approvals or re-approvals for SMHS may not be based on any other criteria than Medical Necessity, as described by the California Code of Regulations (CCR) and as further described by Department of Health Care Services and Tulare County policy and procedure.

    B. Initial Assessment: Contractor shall complete an initial assessment to establish medical necessity for all consumers requesting specialty mental health services within fourteen (14) days for adults, and twenty-one (21) calendar days for minors from the consumer's initial visit. The Assessment must be completed in the format designated by the MHP and must be completed and signed by a Licensed Practitioner of the Healing Arts (LPHA).

    C. Assessment Update: As clinically indicated, with best practice being at least annually and/or when clinically significant changes occur in the client's status/condition (e.g. diagnosis change, medical necessity changes), a re-assessment of key indicators of the client's condition will be performed and documented within the chart. Particularly, reassessment will gather information the required to determine if the clinical symptoms, behaviors, and impairments necessary to support medical necessity for Specialty Mental Health Services are present or not.

    D. Content of Assessments shall address the following minimum items and may include additional items described in Tulare County policy and procedure:

        1. In order to provide enough information to support a conferred diagnosis and medical necessity determination, providers must at least address the following areas:

            a) Presenting Problem

            b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health

            c) Mental Health History

            d) Medical History

            e) Medications

            f) Substance Exposure/Substance Use

            g) Client Strengths

            h) Risks, including trauma

i) Mental Status Exam

j) Complete Diagnosis, determined by an LPHA within their respective scope of practice

2. An Assessment shall also include a case formulation section clearly describing support for a given diagnosis and medical necessity determination.

2. Plan of Care

A. Consumer Wellness Plan (CWP): The plan of care shall be completed by the Contractor within thirty (30) days from the first date of current admission.

B. Frequency: The CWP shall be completed by the 30th day in all cases in which services will exceed 30 days. At minimum, the CWP must be updated annually from the date the LPHA signs the prior CWP. CWPs may also be updated whenever clinically indicated but may never be authorized for longer than one (1) year from the date of the LPHA signature on the prior CWP.

C. Content of CWPs shall include the following minimum items and may include additional items described in Tulare County policy and procedure:

1. A description of the impairment(s)/risk/developmental milestones not being met that will be the focus of treatment and the symptoms/behaviors of the included diagnosis causing the impairment(s)/risk/developmental milestones not being met.

a) Consumer plans must be consistent with the primary included diagnosis and resulting impairment(s)/risk/developmental milestones that were identified on the most recent Assessment.

2. Specific, observable or quantifiable goals and objectives.

3. Proposed type(s) of intervention to address the functional impairment(s)/reasonable risk of significant deterioration in current functioning/failure to achieve developmental milestones as identified in the Assessment. Interventions should include description of both the particular service (e.g. ICC, Individual Therapy) and the specific intervention actions pertaining to the service (e.g. motivational interviewing, CBT, referral/linkage to AOD treatment).

4. Proposed duration and frequency of intervention(s).

5. Documentation of the consumer's participation in and agreement with the plan. This includes consumer signature and/or legal representative on the plan and description of the consumer's participation in constructing the plan and agreement with the plan in progress notes.

D. Signature (or electronic equivalent) by a LPHA (the LPHA must be a physician for Medicare or MED-Only consumers) and the consumer and/or consumer's legal representative.

E. Contractor will offer a copy of the consumer plan to the consumer and will document such on the consumer plan.

3. Progress Notes and Billing Records. Services must meet the following criteria, as specified in the MHP's Agreement with the California Department of Health Care Services.

A. All service entries will include the date and time the services were provided.

B. The consumer record will contain timely documentation of care. Services delivered will be recorded in the consumer record as expeditiously as possible, but no later than the timeliness time frame delineated by Tulare County Mental Health policy and procedure.

C. Contractor will document consumer encounters, and relevant aspects of consumer care, including relevant clinical decisions and interventions, in the consumer record.

D. All entries will include the exact number of minutes of service provided and the type of service, the reason for the service as related to how the service addressed the impairment/risk/developmental milestone identified in the Assessment and the CWP, the corresponding consumer plan goal, the clinical intervention provided, the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure or job title..

E. The record must be legible.

F. The consumer record will document referrals to community resources and other agencies, when appropriate.

G. The consumer record will document follow-up care or, as appropriate, a discharge summary.

H. Timeliness/Frequency of Progress Notes

1. Shall be prepared for every service contact including:

a) Mental Health Services (Assessment, Plan Development, Collateral, Individual/ Group/Family Therapy, Individual/Group/Family Rehabilitation);

b) Medication Support Services;

c) Crisis Intervention;

d) Case Management/Targeted Case Management (billable or non-billable).

2. Shall be daily for:

a) Crisis Residential;

b) Crisis Stabilization (1x/23hr);

c) Day Treatment Intensive.

3. Shall be weekly for:

a) Day Treatment Intensive for Clinical Summary;

b) Day Rehabilitation;

c) Adult Residential.

4. On each shift for other services such as Acute Psychiatric Inpatient.

4. Additional Requirements

A. Contractor shall display the Medi-Cal Guide to Mental Health Services Brochures in English and Spanish, or alternate format in their offices. In addition, Contractors shall post grievance and appeal process notices in a visible location in their waiting rooms along with copies of English and Spanish grievance and appeal forms with MHP self-addressed envelopes to be used to send grievances or appeals to the Problem Resolution Coordinator and the Quality Improvement/Managed Care Department.

B. Contractor shall be knowledgeable of and adhere to MHP policies on Beneficiary Rights as outlined in the Guide to Mental Health Services and the Beneficiary Problem Resolution policy and procedure.

a. This includes the issuance of Notice of Adverse Benefit Determination(s) according to frequencies described in the Notice of Adverse Benefit Determination policy and procedure.

C. Contractor shall ensure that direct service staff, attend cultural competency trainings as offered by the County.

D. Contractor shall establish a process by which Spanish speaking staff that provide direct services in Spanish or interpretive services are tested for proficiency in speaking, reading, and writing Spanish language.

E. Contractor shall provide timely access to care and service delivery in the following areas as required by the State MHP standards:

1. Where applicable, 24 hours per day, 7 days per week access to "urgent" services (within 48 hours of request or determination of necessity) and "emergency" services (same day);

2. Access to routine mental health services (1st appointment within 10 business days of initial request. When not feasible, Contractor shall give the beneficiary the option to re-contact the Access team and request another provider who may be able to serve the beneficiary within the 10 business day standard);

3. Access to routine psychiatric (first appointment within 15 business days of initial request).

4. The MHP Quality Assurance/Utilization Management team of Tulare County monitors clinical documentation and timeliness of service delivery.

5. The MHP shall monitor the performance of its contractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the contractors' performance to periodic formal review.

6. If the MHP identifies deficiencies or areas of improvement, the MHP and the contractor shall take corrective action.

F. Contractor shall not create, support or otherwise sanction any policies or procedures that discriminate against Medi-Cal beneficiaries. Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or, in the alternative, Contractor shall offer hours of operation that are comparable to those hours offered to Medicaid fee-for-service consumers, if the provider serves only Medicaid beneficiaries.

G. If the State, CMS, or the HHS Inspector General (Office of Inspector General) determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate and audit the subcontractor at any time.

H. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Notwithstanding Paragraph 29, Order of Precedence, of the General Terms and Conditions (GTC) relevant to this agreement, the 10-year records retention period shall apply to all MHP agreements. This requirement supersedes the 5-year retention period in Paragraph 9 in the GTC.

Reference: Service and Documentation Standards of the State of California, Department of Health Care Services.

Exhibit B-1
Compensation
Fiscal Year 2019/2020

1. COMPENSATION

a. COUNTY agrees to compensate CONTRACTOR for allowed cost incurred as detailed in **Exhibit A**, subject to any maximums and annual cost report reconciliation.
b. The maximum contract amount shall not exceed Seven Hundred Thousand Dollars ($700,000) for Fiscal Year 2019/2020. Payment shall consist of County, State, and Federal funds. 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. Notwithstanding any other provisions of this Agreement, in no event may CONTRACTOR request a rate that exceeds the contracted rate or request a rate that exceeds CONTRACTOR'S published charge(s) to the general public except if the CONTRACTOR is a Nominal Charge Provider.
c. If the CONTRACTOR is going to exceed the Maximum contract amount due to additional expenses or services, it is the responsibility of the CONTRACTOR to request the amendment and provide all supporting documentation that substantiates the increase. No amendments can be requested after April 1, 2020.
d. CONTRACTOR agrees to comply with Medi-Cal requirements and be approved to provide Medi-Cal services based on Medi-Cal site certification.
e. CONTRACTOR shall be responsible for verifying the Consumer's Medi-Cal eligibility status and will take steps to reactivate or establish eligibility where none exists.
f. CONTRACTOR shall certify that all Units of Service (UOS) listed on the invoice submitted by the CONTRACTOR for any payor sources covered by this Agreement are true and accurate to the best of the CONTRACTOR'S knowledge.
g. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in the **Exhibit A** of this Agreement.
h. CONTRACTOR shall permit authorized COUNTY, State and/or Federal agency (ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed hereunder including subcontract support activities and the premises, which it is being performed. The CONTRACTOR shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.
i. In the event the state or federal government denies any or all claims submitted by COUNTY on behalf of the CONTRACTOR, COUNTY will not be responsible for any payment obligation and, accordingly, CONTRACTOR shall not seek payment from COUNTY and shall indemnify and hold harmless COUNTY from any and all liabilities for payment of any or all denied claims, including those claims that were submitted outside the period of time specified in this Agreement.

2. Contract Renewal

a. If applicable, should both parties exercise the right to renew this Contract, the maximum fund amount for this Contract/these Contracts in total per renewal term is identical to the maximum fund amount within the current executed contract unless the Parties agree otherwise.

b. This contract may be renewed if the CONTRACTOR continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The County may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract.

3. ACCOUNTING FOR REVENUES

a. CONTRACTOR shall comply with all County, State, and Federal requirements and procedures, as described in 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. Grants and 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. 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 the consumer receiving services under this Agreement shall be utilized by CONTRACTOR only for the delivery of mental health service units as specified in this Agreement.

4. INVOICING

a. CONTRACTOR shall submit monthly invoices to Tulare County Mental Health Department, Managed Care, 5957 S. Mooney Blvd, Visalia, Ca 93277, no later than fifteen (15) days after the end of the month in which those expenditures were incurred. The invoice must be supported by a system generated a report that validates services indicated on the invoice.
b. Invoices shall be in the format approved by the Tulare County Health & Human Services Agency. All payments made under this Agreement shall be made within thirty (30) days of submission of all required documentation and in accordance with the COUNTY'S payment cycle.
c. 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 twelve (12) months from the month of service to avoid denial for late billing.

5. COST REPORT:

a. Within sixty (60) days after the close of the fiscal year covered by this Agreement, CONTRACTOR shall provide COUNTY with an accurate and complete Annual Cost Report with a statement of expenses and revenue for the prior fiscal year. The Annual Cost Report shall be prepared by the CONTRACTOR in accordance with all applicable Federal, State, and County requirements and generally accepted accounting principles. CONTRACTOR shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. All revenues received by CONTRACTOR shall be reported in its Annual Cost Report and shall

be used to offset gross cost. CONTRACTOR shall maintain source documentation to support the claimed costs, revenues, and allocations, which shall be available at any time to Designee upon reasonable notice. CONTRACTOR shall be responsible for reimbursement to the County upon final settlement.

b. The Cost Report shall be the final financial and statistical report submitted by CONTRACTOR to COUNTY and shall serve as the basis for a final settlement to the CONTRACTOR. CONTRACTOR shall document that costs are reasonable, allowable, and directly or indirectly related to the services to be provided hereunder.
c. CONTRACTOR must keep records of services rendered to Medi-Cal beneficiaries for ten years or until final cost report settlement, Per W&I Code 14124.1.

6. RECONCILIATION AND SETTLEMENT:

a. COUNTY will reconcile the Annual Cost Report and settlement based on the lower of cost or County Maximum Allowance (CMA). Upon initiation and instruction by the State, COUNTY will perform the Short-Doyle/Medi-Cal Reconciliation with CONTRACTOR.
b. COUNTY will perform settlement upon receipt of State Reconciliation Settlement to the COUNTY. Such reconciliation and settlement will be subject to the terms and conditions of this Agreement and any other applicable State and/or federal statutes, regulations, policies, procedures and/or other requirements pertaining to cost reporting and settlements for Title XIX Short-Doyle/Medi-Cal.

7. REPAYMENT OR REIMBURSEMENT TO STATE OR OTHERS:

a. CONTRACTOR agrees that any repayment or reimbursement that must be made by COUNTY to the State of California or others as a result of an audit or conduct by CONTRACTOR, its agents, officers or employees of the programs or services provided under this Agreement shall be paid by CONTRACTOR, out of its own funds, within thirty (30) days after the parties are notified that repayment or reimbursement is due. For purposes of this provision, it is agreed that offsets made by the state are included within the phrase "repayment or reimbursement."
b. It is understood that if the State Department of Health Care Services disallows Medi-Cal claims, CONTRACTOR shall reimburse COUNTY for any and all State and Federal Medi-Cal funds for those disallowed claims, regardless of the fiscal year of the disallowance within sixty (60) days of the State disallowing claims.

8. Overpayments and Prohibited Payments:

a. The County may offset the amount of any state disallowance, audit exception, or overpayment for any fiscal year against subsequent claims from the Contractor.
b. Offsets may be done at any time after the county has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the CONTRACTOR.
c. CONTRACTOR shall report to the County within sixty (60) calendar days of payments in excess of amounts specified by contract standards.
d. CONTRACTOR shall retain documentation, policies, and treatment of recoveries of overpayments due to fraud, waste, or abuse. Such documentation should include timeframes, processes, documentation, and reporting.
e. CONTRACTOR shall provide an annual report of such overpayments to the County.

f. The County shall not furnish any payments to the CONTRACTOR if that individual/entity is under investigation for any fraudulent activity. Payments of this manner will be prohibited until such investigations are complete by the County or State.

9. Audit Requirements

a. The CONTRACTOR shall submit any documentation requested by the County or State in accordance to audit requirements and needs. Documentation can be requested any time and must be supplied within a reasonable amount of time.
b. The audit shall be conducted by utilizing generally accepted accounting principles and generally accepted auditing standards.
c. The County will involve the Contractor in developing responses to any draft federal or State audit reports that directly impact the county.

10. Beneficiary Liability

a. Pursuant to Cal. Code Regs., tit. 9, § 1810.365, the CONTRACTOR or an affiliate, vendor, or sub-subcontractor of the 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 contract, except to collect other health insurance coverage, share of cost, and co-payments.
b. Consistent with 42 C.F.R. § 438.106, the CONTRACTOR or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which the State does not pay the Contractor, for costs of covered services for which the State or the Contractor does not pay the Contractor's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

EXHIBIT B-3

Electronic Health Records Software Charges
Fiscal Year 2019 - 2020

CONTRACTOR NAME

CONTRACTOR understands that COUNTY utilizes Netsmart's Avatar for its Electronic Health Records management. CONTRACTOR agrees to reimburse COUNTY for all user license fees for accessing Netsmart's Avatar, as set forth below:

One time per user license fee	$800.00
Yearly hosting fee per user	$480.00
OrderConnect Medication Management Prescriber yearly per user fee	$889.95
Non-Prescriber yearly per user fee	$165.36
EPCS Token per user	$75.00
EPCS Subscription per user	$96.00
Yearly Maintenance fee per user	$221.12
Personal Health Record yearly per user	$71.85
M*Modal Speech Recognition yearly per user	$812.40
CareConnect Direct Secure Messaging yearly per user	$60.00

Yearly maintenance fee per user: Amount determined based on formula listed below:

Formula: [Total Maintenance Amount ÷ Total Number of Users]

Should CONTRACTOR decide not to utilize Netsmart's Avatar for its Electronic Health Records management, CONTRACTOR will be responsible for negotiating to opt out the following contract period. The CONTRACTOR will be responsible for obtaining its own system for Electronic Health Records management. CONTRACTOR shall be responsible for administrative costs incurred by the County as a result of Contractor's disassociation with County's Electronic Health Record System. Administrative costs will be calculated based on the costs to add an additional staff position in the Mental Health Department as a result of the service provided under this Agreement and/or if user licenses are purchased so the contractor will have the minimal functionality to the EHR system for consumer setup and billing purposes. The administrative billing would be performed on a monthly basis by invoice to the contractor.