FIRST AMENDMENT TO THE AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND PSYNERGY PROGRAMS, INC.

THIS FIRST AMENDMENT, entered into this _____ day of _____, 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and PSYNERGY PROGRAMS, INC., hereinafter called "Contractor";

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, on February 26, 2013, your Board approved an agreement with Psynergy Programs, LLC, for the provision of residential mental health services for the term of March 1, 2013 through June 30, 2015, for an amount not to exceed $495,000; and

WHEREAS, it is now necessary and the mutual desire and intent of the parties hereto to amend the Agreement for the first time increasing the purchase of additional bed days and increasing the maximum obligation by $280,412 to a new maximum of $775,412. There is no change to the term of the agreement.

WHEREAS, the parties wish to amend and extend that Original Agreement.

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. Paragraph 3. Payments is hereby deleted and replaced with the paragraph 3. Payments below:

   In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B." The County reserves the right to withhold payment if the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed SEVEN HUNDRED SEVENTY-FIVE THOUSAND FOUR HUNDRED TWELVE DOLLARS ($775,412).

This Agreement may be terminated by Contractor, the Chief of the Health System or designee at any time without a requirement of good cause upon thirty (30) days' written notice to the other party.

In the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and materials (hereafter referred to as materials) prepared by Contractor under this Agreement shall become the property of the County and shall be promptly delivered to the County. Upon termination, the Contractor may make and retain a copy of such materials. Subject to availability of funding, Contractor shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that portion of the full payment which is determined by comparing the work/services completed to the work/services required by the Agreement.

2. Exhibit A is hereby deleted and replaced with the Exhibit A-1 attached hereto.

3. Exhibit B is hereby deleted and replaced with the Exhibit B-1 attached hereto.

4. All other terms and conditions of the Agreement between the County and Contractor shall remain in full force and effect.

Signature Page to Follow.

IN WITNESS WHEREOF, the parties hereto, by their duly authorized representatives, have affixed their hands.

COUNTY OF SAN MATEO

By:_____
President, Board of Supervisors
San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

Psynergy Programs, Inc.

_____, Acting President & CEO
Contractor's Signature

Date: 11/5/2014

Long Form Agreement/Non Business Associate v 8/19/08

EXHIBIT A – 1 SERVICES
PSYNERGY PROGRAMS, INC.
FY 2013 - 2015

In consideration of the payments set forth in Exhibit B-1, Contractor shall provide the following services:

I. REHABILITATIVE MENTAL HEALTH SERVICES

A. Introduction

1. The following programs are part of Psynergy Programs, Inc. Nueva Vista, located in Morgan Hill, California and Cielo Vista located in Greenfield, California.
Rehabilitative Mental Health Services focus on client needs, strengths, and choices; the client is always involved in service planning and implementation. The goal of rehabilitation is to help clients take charge of their own lives through informed decision making. Integrated services are based on the client's desired results from mental health services (long term goals) concerning his/her own life, and considering his/her diagnosis, functional impairments, symptoms, disabilities, life conditions, recovery, and rehabilitation readiness. Services are focused on achieving specific shorter term personal milestones (measurable objectives) to support the client in accomplishing his/her desired results.

2. Program staffing is multi-disciplinary and strives to reflect the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community which the program serves. Families, caregivers, human service agency personnel and other significant support persons are encouraged to participate in the planning and implementation process to help the client meet his/her needs, choices, responsibilities and desires. Programs are designed to use both licensed and non-licensed personnel who are experienced in providing mental health services.

3. Psychiatric services, medication support and service, and medical oversight will be provided by Contractor's Chief Medical Director, Medication Services Director, and/or Director of Clinical Services.

4. Contractor will coordinate or participate in periodic case conference around clients whose care is shared with County treatment teams. This includes, but is not limited, to clients residing in Nueva Vista, Cielo Vista, and Tres Vista model. Coordination will include treatment plans, client progress, and discharge planning.

B. Services

Contractor shall provide Assessment, Individual Therapy, Group Therapy, Medication support, Vocational Services, Adult Residential and Semi-Supervised Living. These services shall be provided in a manner prescribed by the laws of California and in accord with the applicable laws, titles, rules and regulations, including quality improvement requirements of the Short-Doyle/Medi-Cal Program. The San Mateo County Behavioral Health and Recovery Services (BHRS) Documentation Manual ("County Documentation Manual") is included herein by reference. To the extent that there is inconsistency between a provision in the County Documentation Manual and this Agreement, the provisions of the County Documentation Manual shall prevail. All services are co-occurring capable, trauma-informed and recovery-oriented. All payments under this Agreement must directly support services specified in this Agreement. Contractor shall provide the following services:

1. Residential Services and Supports

Contractor shall provide residential treatment facilities for SMI adults with mental health and co-occurring disorders. As of the effective date of this Agreement, the Residential Treatment Facilities are: Nueva vista, Cielo Vista, and Tres Vista. Treatment and/or rehabilitation services shall be provided in a structured therapeutic community and shall include a range of activities and services for clients who would be at risk of hospitalization or other institutional placement were they not one of these residential programs ("Nueva vista, Cielo Vista, and Tres Vista). Contractor will support clients in their efforts to restore, maintain and apply interpersonal and independent living skills, and to access community support services, and will make available interventions that focus on symptom reduction and management.

a. Ongoing Residential Treatment Services shall include, but not be limited to: assessment/evaluation, plan development, individual and group counseling, rehabilitation services, collateral services, case management and crisis intervention.

b. Eligibility for admission to Residential Treatment Facility and/or Transitional Residential Treatment Services shall be confined to persons with a serious mental illness and functional impairments that require and will benefit from a rehabilitation program. County BHRS Adult Resource Management will authorize and, in the case of multiple applications, will prioritize persons for admission. Admission priority will generally be given to persons coming from more restricted settings such as hospitals and locked sub-acute facilities.

c. Rehabilitation Services (Supported Employment Services, and Training and Consulting)

i. Supported Employment Services

Contractor may provide supported employment and job placement services to San Mateo County adults who have been diagnosed with psychiatric disabilities and co-occurring disorders. Employment specialists shall assist clients in the following: preparing for employment, developing job skills, locating positions for clients in the business community, and offering support once client has secure employment.

2. Specialty Mental Health Services

a. Mental Health Services. The monthly invoice for Mental Health Services must be supported by clinical documentation to be considered for payment. Mental Health Services are reimbursed by minutes of service.

Contractor shall provide Medication Support Services by a licensed psychiatrist for each client pre-authorized for Medication Support Services by the Deputy Director or designee and to the extent medically necessary.

Mental Health Services include:

i. Assessment: Assessment consists solely of the annual assessment required by County to reassess a client for eligibility for mental health treatment.

ii. Individual Therapy: Individual Therapy are those therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments. Individual Therapy is usually delivered to an individual but may include family or significant support persons when the individual is present, but the focus of work is on the client and not on the family system.

iii. Group Therapy: Group Therapy are those therapeutic interventions for more than one client that focuses primarily on symptom reduction as a means to improve functional impairments. It may include group family therapy when families of two or more clients are present, and the client is not present.

iv. Family Therapy: Family Therapy consists of contact with the client and one or more family members and/or significant support persons. Services shall focus on the care and management of the client's mental health conditions within the family system.

v. Collateral Services: Collateral Services consists of contact with one or more family members and/or significant support persons (when the client is not present) which may include consultation and training to assist in better utilization of services and understanding mental illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the client's condition and involving them in service planning and implementation of service plan(s).

vi. Rehabilitation Services: Rehabilitative Services may include any or all of the following: Assistance in improving, restoring or maintaining a client's functional skills, daily living skills, social skills, leisure skills, grooming and personal hygiene skills, medication compliance, and access to support resources.

b. Medication Support

The monthly invoice for Medication Support Services must be supported by clinical documentation to be considered for payment. Mental Health Services are reimbursed by minutes of service.

Contractor shall provide Medication Support Services by a licensed, qualified psychiatrist for each client pre-authorized for Medication Support Services by the Deputy Director or designee and to the extent medically necessary.

Medication Support Services include:

i. Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals, necessary to alleviate the symptoms of mental illness;

ii. Evaluation of the need for medication, prescribing and/or dispensing;

iii. Evaluation of clinical effectiveness and side effects of medication;

iv. Obtaining informed consent for medication(s); and

v. Medication education (including discussing risks, benefits and alternatives with the consumer or significant support persons).

c. Crisis Intervention

i. Crisis Intervention is a service, lasting less than twenty-four (24) hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit.

ii. Contractor shall provide Crisis Intervention if medically necessary.

iii. Crisis Intervention is reimbursed by minutes of service. To be considered for payment Crisis Intervention must be retroactively authorized by the Deputy Director or designee.

iv. All clinical documentation must accompany the monthly invoice.

d. Case Management

The monthly invoice for Case Management must be supported by clinical documentation to be considered for payment. Mental Health Services are reimbursed by minutes of service.

Case Management Services are activities that are provided by Contractor's staff to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed services for eligible clients. Services may include the following:

i. Linkage and Coordination - the identification and pursuit of resources including, but not limited to, the following:

a) Inter- and intra-agency communication, coordination, and referral;

b) Monitoring service delivery to ensure an individual's access to service and the service delivery system; and

c) Linkage, brokerage services focused on transportation, housing, or finances.

ii. Placement Services Supportive assistance to the individual in the assessment, determination of need, and securing of

adequate and appropriate living arrangements including, but not limited to, the following:

a) Locating and securing an appropriate living environment,

b) Locating and securing funding,

c) Pre-placement visit(s)

d) Negotiation of housing or placement contracts,

e) Placement and placement follow-up, and

f) Accessing services necessary to secure placement

II. ADMINISTRATIVE REQUIREMENTS

A. Record Retention

Paragraph 13 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18th) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later. This rule does not supersede professional standards (contractor is allowed to maintain records for a longer period of time if required by other regulations or licenses).

B. Administering Satisfaction Surveys

Contractor agrees to administer/utilize any and all survey instruments as directed by BHRS, including outcomes and satisfaction measurement instruments.

C. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact the Health Equity Initiatives Manager (HEIM) at 650-573-2714 or jafrica@smcgov.org

Out of county contractors must attest to compliance with all of the pertinent cultural competence requirements in their host County contract. Out of

county contractors shall submit to HEIM (jafrica@smcgov.org) by March 31st, documentation of their compliance.

Contractors who are not able to comply with the cultural competence requirements will be asked to meet with the Program Manager and HEIM (jafrica@smcgov.org) to plan for appropriate technical assistance.

D. Licensing Reports

Contractor shall submit a copy of any licensing report issued by a licensing agency to BHRS Deputy Director of Youth Services, Adult and Older Adult Services, or the Manager of AOD Services or their designee, within ten (10) business days of Contractor's receipt of any such licensing report.

E. Documentation of Services

Contractor shall provide all pertinent documentation required for state and federal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). Documentation shall be completed in compliance with the BHRS Policies & Documentation Manual (as defined in Paragraph II. of this Exhibit A) which is located online at: http://smchealth.org/SOCMHContractors, and is incorporated by reference herein. Documentation for AOD services shall be in compliance with the Alcohol and Other Drug Services Provider Handbook which is located online at http://www.aodsystems.com/SMC/Index.htm, and is incorporated by reference herein.

Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes).

F. Certification

Contractor shall maintain all applicable certifications through San Mateo County to provide any of the following reimbursable services: Short-Doyle Medi-Cal, MediCal, Medicare, or Drug MediCal.

G. Ineligible Employees

BHRS requires that contractors identify the eligibility status of employees, interns or volunteers prior to hiring and on an annual basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor

must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting form, Policy #93-11) should a current employee, intern or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns and volunteers by using the following websites:

1. Office of Inspector General

   Contractor may not employ any persons deemed an Ineligible Person by the Office of the Inspector General in the provision of services for the County through this agreement. Any employee(s) of contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County clients or operations. An "Ineligible Person" is an individual who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment or ineligibility. Ineligibility may be verified by checking: www.Exclusions.OIG.HHS.Gov.

2. California department of Healthcare Services (DHCS)

   Contractors providing state funded health services may not employ any persons deemed an Ineligible Person by the California Department of Health Services (CDHS) in the provision of services for the County through this agreement. Any employee(s) of contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County clients or operations. An "Ineligible Person" is an individual who has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. Ineligibility may be verified by checking: http://files.medi-cal.ca.gov/pubsdoco/publications/bulletins/part1/part1bull_l.asp

H. Advance Directives

Contractor will comply with County policies and procedures relating to advance directives.

I. Beneficiary/Patient's Rights

Contractor will comply with County policies and procedures relating to beneficiary/patient's rights and responsibilities as referenced in the agreement Section 10. Compliance with laws; payment of Permits/Licenses.

J. Physician Incentive Plans

Contractor shall obtain approval from County prior to implementing a Physician Incentive Plan as described by Title 42, CFR, Section 438.6(h). The County will submit the Physician Incentive Plan to the State for approval. The State shall approve the Contractor's request for a Physician Incentive Plan only if the proposed Physician Plan complies with all applicable federal and state regulations.

K. Availability and Accessibility of Service

Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

L. Compliance Plan and Code of Conduct

Contractor shall read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct. In addition, Contractor shall assure that Contractor's workforce is aware of compliance mandates, and are informed of the existence and how to use the Compliance Improvement Hotline Telephone Number (650) 573-2695.

M. Beneficiary Brochure and Provider Lists

Contractor agrees to provide Medi-Cal clients who are new to the BHRS System with a brochure (an original of which shall be provided by County) when a client first receives a specialty mental health service from the Contractor. Such brochure shall contain a description of County services available; a description of the process for obtaining County services, including the County's state-wide toll-free telephone number; a list of the County's providers; a description of the County's beneficiary problem resolution process, including the complaint resolution and grievance processes; and a description of the beneficiary's right to request a fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process.

N. Fingerprint Compliance

At County's sole discretion, Contractor certifies that its employees and/or its subcontractors, assignees, and volunteers who, during the course of performing services under this Agreement, have contact with children or any person under his or her care will be fingerprinted in order to determine

whether they have a criminal history which would compromise the safety of children or individuals with whom Contractor's employees and/or its subcontractors, assignees, or volunteers have contact. If said employees and/or subcontractors, assignees, and volunteers have such a criminal history, they shall not have contact with children or others who receive services through this agreement. Fingerprint information received from the Department of Justice (DOJ) shall be retained or disposed of pursuant to DOJ directive. A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

O. Minimum staff Requirements

Contractor shall have on file job descriptions (including minimum qualifications for employment and duties performed) for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement. Contractor agrees to submit any material changes in such duties or minimum qualifications to County prior to implementing such changes or employing persons who do not meet the minimum qualifications currently on file. Contractor service personnel shall be direct employees, contractors, volunteers, or training status persons.

III. GOALS AND OBJECTIVES

Contractor shall ensure that the following outcome objectives are pursued throughout the term of this Agreement:

GOAL 1: To minimize inappropriate or unnecessary state and psychiatric acute hospitalization to the extent clinically appropriate.

Objective 1: No more than ten percent (10%) of all admissions will be discharged to an acute psychiatric level of care.

Objective 2: At least ninety percent (90%) of clients shall rate services as satisfactory.

End of Exhibit A-1.

EXHIBIT B – 1PAYMENTS AND RATES
PSYNERGY PROGRAMS, INC.
FY 2013 - 2015

In consideration of the services provided by Contractor in Exhibit A-1, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

A. Contract Maximum

The maximum amount that County shall be obligated to pay for all services provided under this Agreement shall not exceed the amount stated in Paragraph 3 of this Agreement. Furthermore, County shall not pay or be obligated to pay more than the amounts listed below for each component of service required under this Agreement.

In any event, the maximum amount County shall be obligated to pay for all services rendered under this Agreement shall not exceed SEVEN HUNDRED SEVENTY-FIVE THOUSAND FOUR HUNDRED TWELVE DOLLARS ($775,412).

B. County shall pay Contractor for up to a maximum of ten (10) beds per month according to the following rates of payment:

1. Maximum Amount By Service Component

Patch rate varies as follows:

$125/day	for dual dx until d/c'd by Psynergy Clinician.
$94/day	for Co-Morbid Dx until de/c'd by Community Medical Professional.
$94/day	for first 90 days from an Acute/IMD placement.
$64/day	for 91st day going forward to discharge.

March 1, 2013 through June 30, 2013

The maximum amount County shall pay Contractor under this Agreement shall not exceed SIXTY-SIX THOUSAND FOUR HUNDRED TWENTY SEVEN DOLLARS ($66,427).

July 1, 2013 through June 30, 2014

The maximum amount County shall pay Contractor under this Agreement shall not exceed TWO HUNDRED FIFTY TWO THOUSAND SEVEN HUNDRED THIRTY-FIVE DOLLARS ($252,735).

July 1, 2014 through June 30, 2015

The maximum amount County shall pay Contractor under this Agreement shall not exceed FOUR HUNDRED FIFTY SIX THOUSAND TWO HUNDRED FIFTY DOLLARS ($456,250).

C. Rates for Services

1. Medication Support Services, Mental Health Services, Case Management, and Crisis Intervention.

   a. Medication Support Services described in Paragraph I.B.3.b of Exhibit A, County shall pay Contractor at the rate of FOUR DOLLARS AND EIGHTY-TWO CENTS ($4.82) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.

   b. Mental Health Services described in Paragraph I.B.3.a of Exhibit A, County shall pay Contractor at the rate of TWO DOLLARS AND SIXTY-ONE CENTS ($2.61) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.

   c. Crisis Intervention Service described in Paragraph I.B.3.c of Exhibit A, County shall pay Contractor at the rate of THREE DOLLARS AND EIGHTY-EIGHT CENTS ($3.88) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.

   d. Case Management described in Paragraph I.B.3.d of Exhibit A, County shall pay Contractor at the rate of TWO DOLLARS AND TWO CENTS ($2.02) per minute. County shall pay such rate less any third-party payments as set forth in Paragraph I.N. of this Exhibit B.

2. Payment shall be made on a monthly basis upon County's receipt of the following:

   a. All required documentation adhering to Medi-Cal guidelines,

   b. Documentation for each minute of service, and

   c. Documentation relating to each appropriate authorization.

D. Payment for temporary absences shall be made according to the following state policies as outlined in Department of Mental Health Letter 86 01:

1. Payment for temporary absence in the supplemental services program and for life support services in residential care facilities can be limited to seven (7) days per month. Such payment is allowable only under all of the following conditions:

    a. the absence is consistent with the client's service and treatment plans;

    b. the absence is necessary for the client's progress or maintenance at this level of care;

    c. the absence is planned, or anticipated; and

    d. the absence, as well as the purpose(s) of the absence, are documented.

2. Payment for temporary absence for purposes of acute hospital or acute non-hospital (psychiatric health facility) treatment, or for treatment in other facilities which meet Title 9 staffing standards (Section 663), except as provided in section II, paragraph 2(a) above, can be limited to ten (10) days per month. Payment is allowable if such treatment is necessary for the client to return to this level of care, i.e., in a residential care facility, and if the purpose(s) is documented.

E. Modifications to the allocations in Paragraph A of this Exhibit B may be approved by the Chief of the Health System or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

F. In the event this Agreement is terminated prior to June 30, 2015 Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the Chief of the Health System or designee.

G. Monthly Invoices and Payment

1. Contractor shall bill County on or before the tenth (10th) working day of each month following the provision of services for the prior month. The invoice shall clearly summarize direct and indirect services (if applicable) for which claim is made.

    a. Direct Services/Claims

Completed Service Reporting Forms or an electronic services file will accompany the invoice and provide back-up detail for the invoiced services. The Service Reporting Forms will be provided by County, or be in a County approved format, and will be completed by Contractor according to the instructions accompanying the Service Reporting Forms. County reserves the right to change the Service Report Forms, instructions, and/or require the Contractor to modify their description of services as the County deems necessary. The electronic services file shall be in the County approved Avatar record format.

b. Indirect Services /Claims

Indirect services (services that are not claimable on the Service Reporting Form or electronically) shall be claimed on the invoice and shall be billed according to the guidelines specified in the contract.

2. Payment by County to Contractor shall be monthly. Claims that are received after the tenth (10th) working day of the month are considered to be late submissions and may be subject to a delay in payment. Claims that are received 180 days or more after the date of service are considered to be late claims. County reserves the right to deny invoices with late claims or claims for which completed service reporting forms or electronic service files are not received. Claims may be sent to:

County of San Mateo
Behavioral Health and Recovery Services
225 37th Avenue, Third floor
San Mateo, CA 94403

H. Revenue and Performance

County anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, the maximum payment obligation and/or payment obligations for specific services may be reduced at the discretion of the Chief of the Health System or designee.

I. Disallowances

In the event Contractor claims or receives payment from County for a service, reimbursement for which is later disallowed by County or the State of California or the United States Government, then Contractor shall promptly refund the disallowed amount to County upon request, or, at its option, County may offset the amount disallowed from any payment due or become due to Contractor under this Agreement or any other agreement.

J. Inadequate Performance

If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, to review documentation, billing and/or other reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies. This Agreement may be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 4 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

K. County May Withhold Payment

Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including, assessment, service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the BHRS Quality Improvement Manager. Contractor shall meet quarterly with County contract monitor, as designated by the BHRS Deputy Director, Adult and Older Adults, to review documentation and billing reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies.

L. Election of Third Party Billing Process

Contractor shall select an option for participating in serial billing of third-party payors for services provided through this Agreement through the completion of Attachment C – Election of Third Party Billing Process. The completed Attachment C shall be returned to the County with the signed Agreement. Based upon the option selected by the Contractor the appropriate following language shall be in effect for this Agreement.

1. Option One

a. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. Within ten (10) days of the end of each month, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph M of this Exhibit B. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.

b. Contractor shall provide a copy of each completed Payor Financial Form (Attachment D) and subsequent annual updates for all clients who receive services through this Agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

2. Option Two

a. Contractor shall provide information to County so that County may bill applicable other third-parties before billing Medi-Cal for services provided by Contractor through this Agreement. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph M of this Exhibit B. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement through the Cost Report reconciliation.

b. Contractor shall provide a copy of the completed Payor Financial Form (Attachment D) and subsequent annual updates for all clients who receive services through this agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

M. Beneficiary Billing

Contractor shall not submit a claim to, 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. The Contractor shall not hold beneficiaries liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, 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 with an emergency psychiatric condition.

N. Claims Certification and Program Integrity

1. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

"Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

Executed at _____ California, on _____20___

Signed _____ Title _____

Agency _____"

3. The certification shall attest to the following for each beneficiary with services included in the claim:

   a. An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement.

   b. The beneficiary was eligible to receive services described in Exhibit A of this Agreement at the time the services were provided to the beneficiary.

   c. The services included in the claim were actually provided to the beneficiary.

   d. Medical necessity was established for the beneficiary as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.

   e. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in this agreement.

   f. For each beneficiary with specialty mental health services included in the claim, all requirements for Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

   g. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

4. Except as provided in Paragraph II.A. of Exhibit A-1 relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

End of Exhibit B

Attachment C
Election of Third Party Billing Process

San Mateo County Behavioral Health and Recovery Services is required to bill all other insurance (including Medicare) before billing Medi-Cal for beneficiaries who have other coverage in addition to Medi-Cal. This is called "serial billing." All claims sent to Medi-Cal without evidence of other insurance having been billed first will be denied.

In order to comply with the serial billing requirement you must elect which of the two following options to use in our contract with you. In either case, you will need to establish the eligibility of your clients through the completion of the standard form (Payor Financial Form) used to collect this information. Please select and complete one of the two options below:

Option One
Our agency will bill other insurance, and provide San Mateo County Behavioral Health and Recovery Services (SMCBHRS) with a copy of the Explanation of Benefits provided by that insurance plan before billing SMCBHRS for the remainder.

We _____(agency name) elect option one.

_____ _____
Signature of authorized agent Name of authorized agent

_____
Telephone number

Option Two
Our agency will provide information to San Mateo County Behavioral Health and Recovery Services (SMCBHRS) so that SMCBHRS may bill other insurance before billing Medi-Cal on our agency's behalf. This will include completing the attached client Payor Financial Form and providing it to the SMCBHRS Billing Office with the completed "assignment" that indicates the client's permission for SMCBHRS to bill their insurance.

We Pathways Programs, Inc (agency name) elect option two.

_____ Arturo M Uribe
Signature of authorized agent Name of authorized agent

408.445.8280
Telephone number

Please note if your agency already bills private insurance including Medicare for services you provide, then you must elect Option One. This is to prevent double billing. Please return this completed form to:

Doreen Avery, Business Systems Manager
Behavioral Health and Recovery Services
225 37th Avenue
San Mateo, CA 94403
(650) 573-2284

Attachment D - Payor Financial Form

AGENCY NAME:		
Client's Last Name/MH ID # (if known)	**First Name M.I.**	**Alias or other names Used**
Client Date of Birth	**Undocumented?** ☐ Yes ☐ No **If no, Social Security Number (Required)**	**26.5 (AB3632)** ☐ Yes ☐ No IEP (SELPA) start date_____

Does Client have Medi-Cal? ☐ Yes ☐ No **Share of Cost?** ☐ Yes ☐ No **Client's Medi-Cal Number (BIC Number)?** _____
Please attach copy of MEDS Screen **If client is Full scope Mcal, skip the remaining sections of this form and fax to MIS/Billing Unit – 573-2110**
Is Client Potentially Eligible for Medi-Cal Benefits? ☐ Yes ☐ No **Client Referred to Medi-Cal?** ☐ Yes, give date: _____ ☐ No
Is this a Court-ordered Placement? ☐ Yes ☐ No
Does Client have Medicare? ☐ Yes ☐ No **If yes, please check all that apply** ___**Part A** ___**Part B** ___**Part D (effective 1/1/06)**
What is the Client's Medicare Number? _____

Responsible Party's Information (Guarantor):

Name _____ Phone _____ Relationship to Client _____ ☐ Self

Address _____ City _____ State _____ Zip Code_____

☐ **Refused to provide Financial Information and will be charged full cost of service.**

FINANCIAL ASSESSMENT – Annual UMDAP (Uniform Method of Determining Ability to Pay)
To determine family's UMDAP liability, please list any other family members currently being seen by Mental Health:

_____

Gross Monthly Income (include all in the Household)
A. Self .....$_____
B. Parents/Spouse/Domestic Partner ....$_____
C. Other .....$_____

Number of Persons Dependent on Income _____

Asset Amount (List all liquid assets)
A. Savings.....$_____
B. Checking.....$_____
C. Stocks.....$_____

Allowable Expenses
A. Court Ordered Monthly Obligation $_____
B. Monthly Child Care Payments (Only if Necessary for Employment) $_____
C. Monthly Dependent Support Payments $_____
D. Monthly Medical Expense Payments $_____
E. Monthly Mandated Deductions for Retirement Plan (Do not include Social Security).....$_____

F. Housing Cost (Mortgage/Rent) $_____

3rd Party HEALTH INSURANCE INFORMATION

Health Plan or Insurance Company (Not employer)

Name of Company _____

Street Address _____

City _____

State _____ Zip _____

Insurance Co. phone number_____

Policy Number _____

Group Number_____

Name of Insured Person_____

Relationship to Client_____

Social Security Number of Insured Person_____ (if other than client)

Does this Client have Healthy Families Insurance? ☐ Yes ☐ No
If Yes, complete San Mateo County Mental Health SED form.

Does this Client have Healthy Kids Insurance? ☐ Yes ☐ No
Does this Client have HealthWorx Insurance.? ☐ Yes ☐ No

CLIENT AUTHORIZATION –This section is not required for Full scope Medi-Cal Clients

I affirm that the statements made herein are true and correct. I understand that I am responsible for paying the UMDAP liability amount or cost of treatment received by myself or by members of my household during each 1-year period. If the cost of service is more than the UMDAP liability amount, I pay the lesser amount. It is my responsibility and I agree to provide verification of income, assets and expenses. If I do not, I will be billed in full for services received. I authorize San Mateo County Mental Health to bill all applicable mental health services to Medi-Care and/or my insurance plan, including any services provided under 26.5. I authorize payment of healthcare benefits to San Mateo County Mental Health.

_____ _____ _____
Signature of Client or Authorized Person Date Reason if client is unable to sign

Client Refused to Sign Authorization: ☐ **(Please check if applicable)** **Date**_____**Reason**_____

Name of Interviewer_____ Phone Number_____ Best Time to Contact_____

FAX COMPLETED COPY TO: MIS/BILLING UNIT (650)-573-2110

San Mateo County Mental Health Services Use Only

ENTERED BY	CLIENT ACCOUNT #	DATA ENTRY DATE

Rev 06/05

MEDI-CAL AND HEALTHY FAMILIES/HEALTHY KIDS/HEALTH WORKS ELIGIBLITY

Below are instructions for accessing the State's MEDS (Medi-Cal Eligibility Determination System) to determine eligibility and clearing share of cost through the internet If you do not have access to the internet, please call Bernadette Ortiz (phone: 650-573-2712) or Analiza Salise (phone:650-573-2442) to verify eligibility.

Instructions for Checking Medi-Cal Eligibility Using the Internet

- Go to Internet Explorer
- Type in the URL/address box: **www.medi-cal.ca.gov**
- From the Medi-Cal Home Web Site screen, click Transaction Login
- From the Login Center Transaction Services screen, enter
  User ID: **assigned provider number** (usually five "0's" preceded by your provider #)
  Password: **assigned pin number***

  ***NOTE:**
  - ***If you are already a Medi-Cal provider and don't know your provider pin number (password):*** *your Program Director will need to write a letter* ***to Cathy Bishop, Staff Services Analyst Medi-Cal Oversight.*** *The letter should be faxed to Cathy at* ***(916) 654-6394.*** *On the letter, state the reason why you are requesting it, i.e., lost, never received, etc. and provide your phone number so that she can call you with your provider pin number.*
  - ***If you are already a Medi-Cal provider and this is the first time you are accessing the Medi-Cal Transaction Services:*** *you will need to complete the Medi-Cal Point Of Service (POS) Network/Internet Agreement form (attached) and mail it to the address on the form. This agreement is required for all providers who intend to use the POS Network for clearing SOC.*

- Click on Submit
- From the Transaction Services screen, click on Single Subscriber
- From Perform Eligibility Transaction screen fill in the following fields:

  - *Subscriber ID* – enter the client's Social Security # (without dashes)
  - *Subscriber Birth Date* – enter the client's DOB (mm/dd/yyyy)
  - *Issue Date* – if unknown, enter today's date (mm/dd/yyyy)
  - *Service Date* – enter the date on which the service is to be performed (mm/dd/yyyy)
  - Click on Submit

Helpful Hints:

Click on Back - to return to Transaction Services screen

Clear – press this button to clear the fields in the form

Patient Recall – once any transaction has been performed on a client, pressing this button will fill in the common fields with all of the information from the last transaction. This is useful for using the same client on different transaction (such as an eligibility verification, then a Share of Cost) or for correcting data when a transaction has gone through with incorrect data.

Instructions for Clearing Medi-Cal Share of Cost Using the Internet

- Go to Internet Explorer
- Type in the URL/address box: **www.medi-cal.ca.gov**
- From the Medi-Cal Home Web Site screen, click Transaction Login
- From the Login Center Transaction Services screen, enter
  User ID: **assigned provider number** (usually five "0's" preceded by your provider #)
  Password: **assigned pin number***

  ***NOTE:**
  - ***If you are already a Medi-Cal provider and don't know your provider pin number (password):*** *your Program Director will need to write a letter* ***to Cathy Bishop, Staff Services Analyst Medi-Cal Oversight.*** *The letter should be faxed to Cathy at* ***(916) 654-6394.*** *On the letter, state the reason why you are requesting it, i.e., lost, never received, etc. and provide your phone number so that she can call you with your provider pin number.*
  - ***If you are already a Medi-Cal provider and this is the first time you are accessing the Medi-Cal Transaction Services:*** *you will need to complete the Medi-Cal Point Of Service (POS) Network/Internet Agreement form (attached) and mail it to the address on the form. This agreement is required for all providers who intend to use the POS Network for clearing SOC.*

- Click on Submit
- From the Transaction Services screen, click Perform SOC (Spend Down) Transactions
- From Perform SOC (Spend Down) Transaction screen fill in the following fields:

  - *Subscriber ID* – enter the client's Social Security # (without dashes)
  - *Subscriber Birth Date* – enter the client's DOB (mm/dd/yyyy)
  - *Issue Date* – if unknown, and clearing service for the current month, enter today's date. If you are clearing a retroactive service, you must have the BIC issue date. (mm/dd/yyyy)
  - *Service Date* – enter service date for the "SOC Clearance." (mm/dd/yyyy)
  - *Procedure Code* – enter the procedure code for which the SOC is being cleared. The procedure code is required. (90862, 90841, 90882, etc.)
  - *Total Claim Charge Amount* – enter the amount in dollars and cents of the total bill for the procedure code. (ex. 100 dollars would be entered as 100.00). If you do not specify a decimal point, a decimal followed by two zeros will be added to the end of the amount entered.
  - *Case Number* – optional unless applying towards family member's SOC case
  - *Amount of SOC (Spend Down)* – optional unless a SOC case number was entered
  - Click on Submit
  - Print SOC (Spend Down) Response screen and attached to the Unbillable SD Mcal Billing Services – SOC Has Not Been Met SOC report and return to MIS.

Helpful Hints:

Click on Back - to return to Transaction Services screen

Clear – press this button to clear the fields in the form

Patient Recall – once any transaction has been performed on a client, pressing this button will fill in the common fields with all of the information from the last transaction. This is useful for using the same client on different transaction (such as an eligibility verification, then a Share of Cost) or for correcting data when a transaction has gone through with incorrect data.

Select SOC Case – this item affects how the Patient Recall button (described above) functions. Simply select the circle above the SOC case number that you want the Patient Recall button to use when it fills out the form. Note that the SOC case numbers are only available if the previous transaction was an Eligibility transaction.

The "Last Used" choice contains the SOC Case number that was used if the previous transaction was a SOC transaction. This is also a default choice if none are selected.

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called the "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a or b)

☐ a. Employs fewer than 15 persons.

☒ b. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

ARTURO M URIBE
Name of 504 Person - Type or Print

PSYNERGY PROGRAMS, INC.
Name of Contractor(s) - Type or Print

18225 Hale Ave.
Street Address or P.O. Box

Morgan Hill, California 95037
City, State, Zip Code

I certify that the above information is complete and correct to the best of my knowledge.

Signature

ACTING PRESIDENT & CEO
Title of Authorized Official

11/05/2014
Date

*Exception: DHHS regulations state that:

"If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."