AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND
REGULATORY, RISK, COMPLIANCE SPECIALISTS, INC.

THIS AMENDMENT TO THE AGREEMENT, entered into this _____ day of _____, 2019, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and Regulatory, Risk, Compliance Specialists, 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, the parties entered into an Agreement for review and consultation services on April 11, 2017, for the term of April 1, 2017, through September 30, 2017, in an amount not to exceed $100,000; and

WHEREAS, pursuant to Resolution Number 075429 of the San Mateo County Board of Supervisors, the parties amended the Agreement on September 12, 2017, to add additional consulting services, extend its term by 15 months through December 31, 2018, and increase the maximum amount payable by $500,000 to an amount not to exceed $600,000; and

WHEREAS, on October 23, 2018, the parties further amended the Agreement to increase the maximum amount payable by $100,000, to an amount not to exceed $700,000.

WHEREAS, on January 7, 2019, the parties further amended the Agreement to increase the maximum amount payable by $25,000, to an amount not to exceed $725,000

WHEREAS, the parties wish to further amend the Agreement to add additional consulting services, extend the term of the agreement through December 31, 2019, and to increase the maximum amount payable by $375,000, to an amount not to exceed $1,100,000.

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

1. Section 3. Payments, of the agreement is amended to read as follows:

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in Exhibit A, County shall make payment to Contractor based on the rates and in the manner specified in Exhibit B. County reserves the right to withhold payment if County determines that the quantity or quality of the work performed is unacceptable. In no event shall County's total fiscal

obligation under this Agreement exceed ONE MILLION ONE HUNDRED THOUSAND DOLLARS ($1,100,000). In the event that the County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by the County at the time of contract termination or expiration. Contractor is not entitled to payment for work not performed as required by this agreement.

2. Section 4. Term, of the agreement is amended to read as follows:

   Subject to compliance with all terms and conditions, the term of this Agreement shall be from April 1, 2017, through December 31, 2019.

3. Original Exhibit A and original Exhibit B are replaced with Revised Exhibit A, (rev. 1/4/19) and Revised Exhibit B, (rev. 1/4/19), copies of which are attached hereto and incorporated into the Agreement by this reference.

4. **All other terms and conditions of the agreement dated April 11, 2017, between the County and Contractor shall remain in full force and effect.**

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

For Contractor: Regulatory, Risk, Compliance Specialists, Inc.

Susan Acquisto	1/15/19	Susan Acquisto
Contractor Signature	Date	Contractor Name (please print)

COUNTY OF SAN MATEO

By:
President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:
Clerk of Said Board

Revised Exhibit A
(rev. 1/4/19)

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

Part I: Concurrent Reviews

Based on the ADC and the inpatient Revenue by Payer, it is assumed there are approximately 13,140 patient days for which 4,336 are Medicare patient days annually, 361 patients per month and 12 per day as an average. It is anticipated that concurrent InterQual reviews would be completed on all Medicare patients with communication to Case Management staff, clinical departments along with Medical Advisor. An average of 2-4 hours per day or 12-20 hours per week is anticipated to review inpatient and observation status patients for medical necessity criteria and work with appropriate staff

Part II: Appeals and Denial Management, Coaching Key Physician Staff, Consultation with Interpretation of Regulations

A. Appeals and Denial Management:

San Mateo Medical Center (SMMC) is a Safety Net Hospital currently staffed for 100 beds.
There are 60 licensed medical-surgical beds with an ADC of 32 inpatients and an ADC of 2 Observation patients or 30 hours on average. There are 7 licensed Intensive Care Unit (ICU) beds with an ADC of 4 patients. Ten percent of the inpatient days are patients who do not meet medical necessity by determination of InterQual review. Many of these days when the patient does not meet medical necessity are paid at an administrative day rate. SMMC inpatient is primarily medicine and admits are driven by the Emergency Department. The focus of this ongoing work is develop and appeals management process for medical-surgical and ICU patient denials.

The annual gross revenue stream for these patients is $35M and denials have a significant impact on the revenue stream. For the first six months of 2016, the denials were $4.5M. Per Appendix A referenced in the original proposal, there was a breakdown of denials by payer type, reason, number of accounts, and dollars. In summary, from January 2016 to June 2016, the total denials and dollars denied by payer group were reported:

- Medi-Cal 787 denied claims, $ 3,516,689.00
- Medicare 447 denied claims, $ 872,408.00
- Commercial 50 denied claims $ 165,514.00

Based on the preliminary report of the claims review, 75% of the Medi-Cal claims, 33% of the Medicare Claims and 100% of the commercial claims could have been appealed. Based on those percentages, appeals would average the following per month:

- Medi-Cal 787 x 75%=590/6 months= 98 cases/month
- Medicare 447x 33% =148/6months = 25 cases/month
- Commercial 50x100% =50/6 months= 8 cases/month

B. Coaching and Teaching Key Physician Leaders and Clinical Staff:

As a result of writing appeals, consultant staff will work with clinical case management, nursing and medical staff in development of clinical documentation improvement strategies based on concurrent reviews, denials and successful appeals. Education will be provided to the Chief Medical Officer and coaching with Medical Advisor in her new role on a weekly basis. Consultants will also work with coding manager and physicians in imbedding information to support medical necessity.

C. Consultation and Assistance with Interpretation of Regulations

This consultation service was included in first proposal and some of the work has been

completed with the review and revision of the Revised Inpatient/Outpatient Order Set, Revised Work Flow, CMS 10611 MOON form and MOON Instructions with resources provided, i.e., MAC-Noridian Training PowerPoint and CMS Supporting Statement for MOON Form

The consultant team will review Resource Department Policies and Procedures to:

i. Identify appropriate areas for policies/procedures and recommend drafts of policies/procedures as appropriate.

Identify current changes needed to policies and procedures to ensure regulations have been transitioned appropriately into practice for the following:

ii. Review the documentation of case managers and social workers to determine what may belong in the utilization record and what is appropriate for the patient medical record as part of the care team documentation.

Part III: Continued Reviews, Audit Cases, Denial Management

- Medicare & Medi-Cal Case Reviews: Cindy 100% review; Delores 100% until error rate is 5% then 20 cases per month; Evelyn 100% until error rate is 5% then 20 cases per month; Juana 100% until error rate is less than 5% then 20 cases per month and Joan Terry 100% review
- Continue weekly variance reports and variance analysis reports. (Contractor will change data points if SMMC see value in other information)
- Continue weekly Tuesday meetings to discuss variances, Medicare secondary reviews, discharge planning of patients LOS > 4 days, in service on processes, new policies & procedures, these meetings will be documented with agenda's, written instructions and policies & procedures as needed.
- Continue secondary review process for Medi-Cal cases with Contractor submission of reviews to hospital designated PA('s)
- Continue to work with HPSM - Attend IDT meetings to facilitate discharge of long stay patients. This can be discontinued once the current 2 long stay patients are discharged.
- Audit cases for completion in preparation for DHCS audits
- On-going audits as assigned by Compliance Officer. Topics will include SSUB, Observation, and medical necessity.
- Denial management through submission of appeals
- Authorization process- continue to work with CM & SW on documentation of placement efforts, work with PFS on process for communication to RM regarding authorizations.
- Regulatory, Risk, Compliance Specialist, Inc. (RRCS) will continue with quality control audits of all Medicare and Medi-Cal InterQual and final utilization management determinations completed by SMMC case managers.
- RRCS will report compliance findings and analysis on SMMC case manager work using mutually agreed on data metrics.
- RRCS nurse content expert will continue to work with SMMC physician advisor on the secondary review process for Medi-Cal cases. RRCS will review and provide feedback

and critique to each SMMC case manager on the content of the secondary review request.

- RRCS nurse content expert will continue the liaison role with the California State Department of Health Care Services for quarterly audits.
- RRCS will audit surgical day cases, extended stay cases, and observation status cases for correct status.
- RRCS will assist as requested with denial management through submission of appeals.

Revised Exhibit B
(rev. 1/4/19)

In consideration of the services provided by Contractor described in Exhibit A and subject to the terms of the Agreement, County shall pay Contractor based on the following fee schedule and terms:

Part I: Concurrent Reviews

An average of 12-20 hours per week is average of $11,200.00/month or $134,400 annually. This is anticipated to be the average amount dependent on Medicare census and number of reviews per day/week.

Part II: Appeals and Denial Management, Coaching Key Physician Staff, Consultation with Interpretation of Regulations

A. Appeals and Denial Management: Start with 50 cases per month x 1.75 hours/case x $175.00/hour = $15,312.50/ month. The varying monthly caseload would be assigned by Patient Financial Services via a work queue so that cases referred to consultant staff have been approved by hospital financial management staff prior to assignment. The fees would be based on actual number of appeals completed. As case management processes are refined and physician education is completed, it is anticipated the denials would significantly decrease.

B. Coaching and Teaching Key Physician Leaders and Clinical Staff: 16 hours per week x 20 weeks =320 hours/$175.00 per hour=$56,000.00 with hours provided onsite and off-site to work with staff and develop clinical documentation training and information.

C. Consultation and Assistance with Interpretation of Regulations: $8,000 for the remainder of the consultation and assistance