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SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Riverside County Department of Mental Health

SUBMITTAL DATE: January 18, 2012

SUBJECT: Approve the In-State Children's Program Mental Health Amendment for Community Access Network, Inc. (All Districts)

RECOMMENDED MOTION: Move that the Board of Supervisors ratify and:

1. Approve the FY 2011/2012 agreement amendments with Community Access Network, Inc. increasing the contract amount from $99,999 to $699,999;
2. Authorize the Chairman of the Riverside County Board of Supervisors to sign the agreement amendment;
3. Exempt the Riverside County Purchasing Agent from the sole source procurement requirement when adding new vendors; and authorize the Purchasing Agent to sign agreements with approved, existing In-State Children's Program mental health service providers that exceed the $100,000 purchasing authority without having to obtain prior Board approval when using the same Board approved boiler plate agreement used with Community Access Network and while staying in the approved aggregate amount of $13,738,970; and
4. Authorize the Riverside County Purchasing Agent to increase, decrease, amend, and annually renew all the In-State Children's agreements as listed in Attachment "A" while staying within the previously Board of Supervisors approved aggregate amount of $13,738,970 for In-State Children's Provider contracts through June 30, 2015.

BACKGROUND: On December 6, 2011, Agenda Item 3.22, the Riverside County Board of Supervisors approved the Riverside County Department of Mental Health's (RCDMH) utilization of In-State Children's Services contracts as specified in Attachment "A" to provide various mental health services during FY 2010/2011 for an approved aggregate amount of $13,738,970; and **(Continued on page 2)**

JW:DF

Jerry Wengerd, Director
Department of Mental Health

FINANCIAL DATA	**Current F.Y. Total Cost:**	$ 13,738,970	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$ 0	**Budget Adjustment:**	No
	Annual Net County Cost:	$ 0	**For Fiscal Year:**	11/12

SOURCE OF FUNDS: See Attachment "A"

"Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION: APPROVE

BY: Debra Cournoyer

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: ELENA M. BOEVA 1-18-12 DATE

Purchasing: Mark Seiller, Assistant Director

Policy ☒ Consent ☐ Dep't Recomm.
Policy ☒ Consent ☐ Per Exec. Ofc.

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

Prev. Agn. Ref.: 3.22 of 12/06/2011, 3.41 of 07/29/2010, 3.96 of 07/29/08,

District: ALL

Agenda Number: 3.15

SUBJECT: Approve the In-State Children's Program Mental Health Amendment for Community Access Network, Inc.

BACKGROUND (continued):

authorized the Riverside Purchasing Agent to annually renew these agreements through June 30, 2013. Subsequently, in FY 2010/2011 and FY 2011/2012, the Purchasing Agent exercised their Board of Supervisors' given authority to renew the agreements as outlined in Attachment "A".

The RCDMH is required to provide Therapeutic Behavioral Services (TBS) as a result of a court order issued in May of 1999 by the U. S. District Court of Central California. This court order requires that Medi-Cal provides reimbursement to local government agencies for the provision of TBS as a supplemental service for qualifying Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) recipients. In addition, the State of California also requires the RCDMH to provide TBS to a minimum of four percent (4%) of the eligible Medi-Cal beneficiaries served by RCDMH.

The RCDMH In-State Children's contracts listed in Attachment "A" are for mental health services provided to eligible youth between the ages of 0-21, which includes the provision of Medi-Cal and Therapeutic Behavioral Services (TBS) to individuals placed in group homes. Mental Health TBS are intended to equip the youth with the social and mental health skills for them to more effectively manage the specific-behavior(s) that have historically presented a barrier to them achieving residency in the lowest and most appropriate level of care.

The RCDMH is currently experiencing an influx of TBS referrals for FY 2011/2012 and as a result, there has been a substantial increase in contractor services rendered. Historically, the RCDMH noticed that the number of eligible clients has fluctuated on an annual basis depending on the number of eligible beneficiaries. Therefore, RCDMH is requesting that the Board of Supervisors sign the Community Access Network, Inc. agreement amendment as outlined in Attachment "A" for $699,999; and authorize the RCDMH to continue contracting with the existing In-State Providers for TBS and other required mental health services, also specified in Attachment "A", for the previously Board of Supervisors approved aggregate amount of $13,378,970 for FY 2011/2012 through June 30, 2015.

PERIOD OF PERFORMANCE:
The specified In-State Children's Services contracts have a period of performance of July 1, 2011 to June 30, 2012, and may be renewed annually through June 30, 2015. Each contract has a termination provision that may be exercised, based upon availability of Federal, State or County funds.

FINANCIAL IMPACT:
Attachment "A" provides the maximum contract amounts for the Community Access Network, Inc. agreement amendment and for each of the In-State Children's Program Mental Health agreements. Community Access Network, Inc. has historically provided TBS at a rate that is less than the approved State Maximum Allowances (SMA) for Short Doyle / Medi-Cal services, which results in a cost savings to the County. Funding for these contracts was budgeted in the RCDMH's FY 2011/2012 budget. No additional County funds are required.

JUSTIFICATION FOR DELAY:
Due to the aforementioned influx of TBS clientele, the RCDMH performed a detailed assessment on its TBS State required contracts, and has recently determined that this contract, and others, will require a substantial increase in order to fulfill the State's mandate for the department to provide TBS.

ATTACHMENT "A"
RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
MAXIMUM CONTRACT AMOUNT FY 2011/12

Amendment for FY 2011/2012 Central Children's Contracts for Board Approval

Contractor	Previous Contract Amount	Amended Contract Amount
Community Access Network, Inc	$99,999	$699,999
SUBTOTAL	$99,999	**$699,999**

FY 2011/2012 **Previously Approved** Central Children's Contracts

Contractor	Contract Amount
Charlee	$ 844,538
Childhelp, Inc.	$ 139,999
EMQ Families First	$ 99,943
JDT Consultants	$ 99,999
Milhous Services, Inc.	$ 280,179
New Haven	$2,156,558
Pacific Clinics	$1,261,020
Rebekah Children's Services	$ 101,162
San Diego Center for Children	$ 199,144
South Coast Society	$ 99,999
Starview Adolescent Center, Inc.	$ 198,431
Sunbridge Harbor View	$ 180,686
Victor Community Support Services	$ 946,581
Victor Treatment	$ 131,550
Vista Del Mar	$ 120,909
SUBTOTAL	**$6,860,698**

FY 2011/2012 **Previously Approved** Western Children's Contracts

Contractor	Contract Amount
Carolyn E. Wylie Center	$ 55,100
Family Service Association	$ 234,524
Oak Grove	$ 500,000
Olive Crest	$1,000,000
VCSS – FAST	$ 774,622
VCSS – Lake Elsinore	$3,072,698
SUBTOTAL	**$5,636,944**

ATTACHMENT "A"
RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH
MAXIMUM CONTRACT AMOUNT, FY 2011/12

SUMMARY

One (1) Amendment Contract	$	699,999
Previously Approved Central Children's Contracts	$	6,860,698
Previously Approved Western Children's Contracts	$	5,636,944
Subtotal	$	13,197,641
Reserve	$	541,329
GRAND TOTAL AGGREGATE AMOUNT (Previously Approved by the Board of Supervisors)	**$**	**13,738,970**

FY 2011/12
FIRST AMENDMENT TO THE AGREEMENT
BETWEEN
COUNTY OF RIVERSIDE AND
COMMUNITY ACCESS NETWORK, INC.

That certain agreement between the County of Riverside (COUNTY) and Community Access Network, Inc. (CONTRACTOR) originally approved by the Riverside County Purchasing Agent on April 19, 2011 for FY 2010/2011; extended by the Purchasing Agent on August 25, 2011 for FY 2011/2010; and is hereby amended for the first time for FY 2011/2012, effective July 1, 2011 through June 30, 2012, as follows:

- Add Exhibit A-2 for Behavioral Coaching Services for FY 2011/2012.
- Rescind the previous Exhibit A-1 in its entirety and replace it with the new, attached Exhibit A-1 for FY 2011/2012.
- Rescind the previous Exhibit C in its entirety and replace it with the new, attached Exhibit C in which the County's maximum obligation to the Provider is increased from $99,999 to $699,999 for FY 2011/2012.
- Rescind the previous Schedule I in its entirety and replace it with the new, attached Schedule I for FY 2011/2012.
- All other provisions of this entire Agreement shall remain unchanged.

IN WITNESS WHEREOF, the Parties hereto have caused their duly authorized representative to execute this Amendment.

COUNTY ADDRESS:
County of Riverside
Board of Supervisors
4080 Lemon Street, 5th Floor
Riverside, CA 92501

INFORMATION COPY:
County of Riverside
Department of Mental Health
P.O. Box 7549
Riverside, CA 92503-7549

CONTRACTOR
Community Access Network, Inc.

Signed: ____________________

Date: 1-10-2012

Title: Executive Director

Address: ~~1307 W. Sixth Street, Ste. 109~~
Corona, CA 92882
2275 S. Main St Ste. 201
Corona, CA 92882

COUNTY OF RIVERSIDE

Signed: ____________________
John F. Tavaglione, Chairman
Riverside County Board of Supervisors

Date: ____________________

COUNTY COUNSEL:
Pamela J. Walls
Approved as to Form

By: ____________________
Deputy County Counsel

Attest by: ____________________
Kecia Harper-Ihem, Clerk of the Board

Rev.12/07/11

EXHIBIT A-1

CONTRACTOR NAME: COMMUNITY ACCESS NETWORK, INC.

DEPT. ID/PROGRAM NO: ***4100207246.83550***

THERAPEUTIC BEHAVIORAL SERVICES EXHIBIT

MODE OF SERVICE	SERVICE FUNCTION
Outpatient Services	Therapeutic Behavioral Services

I. SCOPE OF SERVICES:

CONTRACTOR shall provide Therapeutic Behavioral Services (TBS) as a singular service to minors referred by DMH who receive specialty mental health services paid for by Medi-Cal in other programs.

A. THERAPEUTIC BEHAVIORAL SERVICES GENERAL DESCRIPTION:

CONTRACTOR shall provide Therapeutic Behavioral Services, where authorized by Mental Health. Therapeutic Behavioral Services (TBS) are interventions, which may include support for the family, foster family or support system's efforts to provide a positive environment for the child/youth. TBS is intended to supplement other specialty mental health services by addressing the target behavior(s) or symptoms that are jeopardizing the child/youth's current living situation or the planned transition to a lower level of placement.

The purpose of providing TBS is to further the child/youth's overall treatment goals by providing additional one on one behavioral intervention services during a short term period. All services must be in compliance with State Department of Mental Health letter #99-03 & other state letters on TBS.

TBS will be decreased when the identified behavioral benchmarks have been reached or when reasonable progress towards the behavioral benchmarks are not being achieved and are not reasonably expected to be achieved in the clinical judgment of the TBS Treatment Team; which is comprised of the child/youth's Specialty Mental Health Provider (SMHP) (i.e., primary case manager and/or therapist), the CONTRACTOR's clinical staff and the parent/caregiver, and COUNTY TBS Liaison. These services are

intended to be short-term and not intended to provide childcare or basic supervision or to maintain a child/youth at a specified level for the long term.

CONTRACTOR must be able to provide services any time of the day, seven (7) days a week as needed to address specific service plans.

B. TARGET POPULATION TO BE SERVED:

The primary target population for TBS is full scope Medi-Cal eligible individuals 0-21 years old who meet the Mental Health Plan medical necessity criteria, are receiving other Medi-Cal funded mental health services, and are highly likely, without TBS, to be at risk of placement at a higher level of residential care or hospitalization or the child/youth in the highest levels, needs these services to transition to a lower level of residential placement.

C. CONTRACTOR RESPONSIBILITIES:

The CONTRACTOR must be a certified Medi-Cal provider and is responsible for all aspects of TBS. The CONTRACTOR shall hire, train and supervise staff. Existing staff may be utilized for this purpose; however, TBS supervisor and staff should be distinct from group home staff to facilitate the separation between TBS and Group Home services (if applicable). They also shall document and bill the service, and report the costs associated with the service to the COUNTY for reimbursement.

The CONTRACTOR is expected to follow all of the usual procedures and policies as in any other Medi-Cal funded service including case documentation.

Additional responsibilities are as follows:

1. CONTRACTOR shall be prepared to provide TBS at off-site facilities as appropriate, including the group home, client's home, foster home or community.
2. Identify a TBS clinical supervisor and back up, both of which must be Licensed in California as a Licensed Practitioner of the Healing Arts (LPHA), who shall also act as liaison with the COUNTY of Riverside and oversee the CONTRACTOR's TBS program and staff. This individual shall take all referrals, ensure completion of the TBS Assessment including a Functional Analysis of Behavior (FAB) for each target

1 behavior, assign and supervise staff. Each CONTRACTOR must develop and
2 submit to the COUNTY their own rationale for establishing Supervisory caseloads
3 maximums and ensure staff is hired in a timely manner to meet stated maximums.
4 Please see COUNTY recommendation for TBS Supervisory Caseload Guidelines.
5 3. CONTRACTOR shall complete an initial, monthly and discharge Behavioral
6 Assessment Form (BAF) on each TBS case they serve and submit them monthly to
7 the COUNTY for data processing, while maintaining a copy of each BAF in the
8 TBS chart. Monthly BAFs and Monitoring Tools are to be completed for each TBS
9 Treatment Team Meeting.
10 4. Provide education and training to TBS staff on a regular basis and make staff
11 available to attend required training related to the provision of TBS.
12 5. Ensure required TBS Treatment Team planning meetings occur with TBS Liaison
13 and TBS staff participates in consultation as determined by current county policy.
14 6. Ensure TBS staff provides a minimum of bi-weekly feedback to the SMHP
15 regarding the status of TBS, and document progress of TBS Treatment Plan
16 interventions and continued client needs.
17 7. Ensure appropriate documentation occurs which meets Medi-Cal standards.
18 8. Ensure that all treatment plans are signed by the Client, Caregiver, TBS Clinical
19 Supervisor, SMHP, and TBS Coach. Any exception to obtaining one of these
20 signatures should have a corresponding note in the Client's chart.
21 9. Audit TBS charts on a regular basis as evidenced by TBS Clinical Supervisor's
22 signature on each billed progress note.
23 10. Track hours billed against hours worked and progress notes submitted.
24 11. CONTRACTOR shall develop an intervention plan, identify specific target
25 behavior(s), proposed hours, and proposed times of services. The CONTRACTOR
26 shall coordinate services with the child/youth's SMHP and family.
27 12. Cooperate with COUNTY contract monitoring team for monthly, quarterly and
28 annual reviews.

13. CONTRACTOR shall respond to referrals within two (2) business days. If CONTRACTOR is unable to establish contact with TBS Treatment Team members within the first week and set the initial Treatment Team meeting date within three weeks of the receipt of the TBS Referral, then CONTRACTOR is to notify the COUNTY TBS Liaison and document the notification.

14. Notify COUNTY in writing of any special incidents (injury, altercations, etc.) occurring during the delivery of TBS.

CONTRACTOR shall remain a Medi-Cal certified provider.

D. STAFFING:

TBS shall be provided by licensed staff, trained unlicensed Board of Behavioral Sciences registered or paraprofessional staff members who are under the direction of a licensed clinician. TBS providers must meet the organizational provider qualifications already established in Title 9, CCR, Section 1810.435. In addition, both individuals who assess beneficiaries to determine the need for TBS and individuals who provide direct TBS interventions must meet the requirements of the Judgment and Permanent Injunction in Emily Q. v. Bontá, which requires that TBS providers have training in behavior analysis with an emphasis on positive behavioral interventions. The TBS staff person must be available at the designated site of service to:

1. Provide structure and support.
2. Assist the child/youth in engaging in appropriate activities.
3. Minimize impulsivity.
4. Increase social and community competencies by building or reinstating those daily living skills that will assist the child/youth to live successfully in the community.
5. Implement interventions identified in the TBS Treatment Plan with the client and Caregivers, modeling and guiding them in their use of these interventions.

The TBS staff also serves as a positive role model and assists in developing the child/youth's ability to sustain self-directed appropriate behavior, internalize a sense of social responsibility, and/or enable participation proactively in community activities.

1 TBS staff must be available to participate in weekly/monthly conference calls and
2 provide feedback on progress of the intervention and continued client needs.

3 E. COORDINATION BETWEEN TBS AND OTHER SERVICES:

4 TBS is provided to children and youth who are also receiving at least one other
5 specialty mental health service paid for by Medi-Cal. Therefore, there is a potential for
6 the child/youth to be receiving TBS at the same time and location that the child/youth is
7 participating in other programs. All specialty mental health services, including TBS,
8 must provide a clear audit trail and be identified as the appropriate intervention
9 necessary to support the beneficiary's efforts in attaining the objectives necessary to
10 achieving the goals of their Treatment Plan(s).

11 1. The role of the staff providing TBS is to implement the TBS Treatment Plan by
12 providing the interventions addressing the specific problem behaviors and/or
13 symptoms TBS is intended to resolve.
14 2. TBS is provided face-to-face by one provider to the child/youth for whom the
15 services are authorized.
16 3. TBS involves individualized proactive interventions, not general supervision per
17 DMH Information Notice 02-08.
18 4. TBS must be provided in a manner that decreases the need for TBS and should not
19 foster dependency.
20 5. TBS staff providing TBS to a child/youth for specified hour may not provide TBS
21 to another child/youth during that same time frame, as TBS is a one-to-one service.
22 6. Transporting a child/youth is not a reimbursable TBS activity. Accompanying a
23 child/youth who is being transported may be reimbursable, depending on the
24 specific circumstances.
25 7. Staff providing TBS are not authorized to provide seclusion or restraint.
26 8. TBS must be clearly differentiated from other mental health services as stabilizing a
27 situation in which a child/youth is at risk of placement in an RCL 12 to 14 group
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home, or locked facility for the treatment of mental health needs, or to enable transition from any of those levels to a lower level of residential care.

It is expected that the direct TBS provider would have contact with the child/youth's parents/caregivers. The TBS provider would be delivering "Collateral TBS" when working with the parent/caregiver towards the goals of the child/youth's TBS Treatment Plan. Direct TBS providers making use of Collateral TBS activities must ensure that the collateral contact meets the requirements of Title 9, CCR, Sections 1810.206 and 1840.314. The contact must be with individuals identified as significant in the child/youth's life and must be directly related to the needs, goals and interventions of the child/youth as identified on the TBS Treatment Plan and documented as such.

II. ADMINISTRATIVE

A. COUNTY'S RESPONSIBILITY:

1. Make referrals of clients to CONTRACTOR using established procedures.
2. Provide CONTRACTOR with initial and on-going payment authorizations of TBS upon request in accordance with COUNTY procedure, DMH Information Notice 02-08 and DMH Letter 04-02 and 04-03.
3. Coordinate any COUNTY operated therapy services with TBS services.
4. Assist in problem solving issues around clients and programs.

B. AUTHORIZATION PROCESS FOR TBS:

Authorization procedures are to be made in compliance with current DHM Information Letters and Notices.

1. CONTRACTOR is required to request service authorization for TBS in advance of the delivery of the services included in the authorization request.
2. The initial service authorization may not exceed 30 days. The initial authorization will cover the CONTRACTOR conducting an initial TBS Assessment with a FAB, which must identify at least one symptom or behavior, along with the function it serves that TBS will address; developing an initial TBS Treatment Plan, which must identify at least one unique TBS intervention linked specifically to the strengths or

interests of that client and serve the same function of the behavior to be replaced; complete the Behavior Assessment Form; and providing the initial delivery of direct one-to-one TBS once TBS Assessment is completed.

3. When the CONTRACTOR received an initial authorization for 30 days, the CONTRACTOR'S first request for reauthorization must include a TBS Treatment Plan that meets the criteria specified in the "TBS Client Plans" section of DMH Information Notice 02-08.
4. When the CONTRACTOR'S initial request for COUNTY service authorization has concluded, upon receipt of TBS Assessment with a FAB, initial TBS Treatment Plan, and Behavior Assessment Form; the COUNTY may reauthorize TBS if fully supported by the above-mentioned items. Reauthorizations may be approved for 60 days.
5. Reauthorizations must be based upon clear documentation of the following and any additional information from the TBS provider required by the COUNTY:
   a. The child/youth's progress towards the specific goals and timeframes of the TBS Treatment Plan. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the child/youth in making progress towards specified measurable outcomes identified in the TBS plan or the child/youth has reached a plateau in benefit effectiveness.
   b. If applicable, the child/youth's lack of progress towards the specific goals and timeframes of the TBS Treatment Plan and changes need to be addressed.
   c. If the TBS being provided to the child/youth has not been effective and the child/youth is not making progress as expected towards identified goals, then alternatives must be considered. If TBS is going to be continued then the rational for continuing TBS must be clearly identified.

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d. Significant changes in the child/youth's environment must be reviewed and any updates necessary must be added to the TBS Treatment Plan (e.g., a change in residence).

e. The progress and provision of skills and strategies being provided to parents/caregivers to ensure continuity of care when TBS is discontinued.

C. <u>ADMINISTRATIVE:</u>

CONTRACTOR will be reimbursed for all time spent providing the direct services plus travel and documentation time. Supervision of CONTRACTOR's TBS staff and liaison time with the COUNTY is an indirect cost that must be included in the per minute rate, as they are not direct Medi-Cal reimbursable services.

1. Items will be recouped for the following reasons:

   a. No progress note was found for service claimed in accordance with DMH Letter No. 99-03, pages 6-7.

   b. No documentation of a plan for TBS in accordance with DMH Letter No. 99-03, pages 6-7.

   c. Per DMH Letter No. 99-03, page 4; progress notes clearly indicate that TBS was provided solely for one of the following reasons:

      1) For the convenience of the family, caregivers, physician, or teacher.

      2) To provide supervision or to ensure compliance with terms and conditions of probation.

      3) To ensure the child/youth's physical safety or the safety of others, e.g., suicide watches.

      4) To address conditions which are not a part of the child/youth's mental health condition.

   d. The progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility in accordance with DMH Letter No. 99-03, page 5.

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e. The progress note clearly indicates that TBS was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal; per CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9).

f. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for FFP, e.g., Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per Title 9, Chapter 11 (CCR, Title 9, Chapter 11, Sections 1840.312(g)&(h) and 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)).

2. TBS should be separated into three categories: TBS (394) Coach Time (face-to-face), TBS – Assessment (395), & TBS – Collateral (396). The procedure codes and service definitions of service are as follows:

a. TBS Coach Time (394) – Therapeutic Behavioral Services are a one-to-one (face-to-face) therapeutic contract between a mental health provider (TBS Coach) and a beneficiary for a specified short-term period of time, which is designed to maintain the child/youth's placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals.

1) TBS Coach Time may not begin until the initial Assessment is completed.

2) The majority of TBS billing should fall under this category.

b. TBS – Assessment (395) – A service activity conducted by the TBS Clinical Supervisor, or under the TBS Clinical Supervisor's direction by a Board of Behavioral Sciences registered Marriage and Family Therapist (MFT) Intern, or registered Licensed Clinical Social Worker (LCSW) Associate, which must include the FAB and the initial BAF based on information gained through consultation with Specialty Mental Health Service Provider, Parent/Caregiver and Beneficiary. The Assessment must focus on identifying the child/youth's Target Behaviors and/or symptoms that jeopardize continuation of the current residential placement or that are expected to interfere when a child/youth is

transitioning to a lower level of residential placement. TBS Assessment service activity will include TBS Assessment and TBS Treatment Plan development time. This service is not always a direct face-to-face service. An Assessment may include the following: a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural and environmental issues; and diagnosis.

1) Documentation to be completed is the FAB for each of the identified Target Behaviors that are jeopardizing placement, initial BAF and a TBS Treatment Plan.

c. TBS – Collateral (396) – A service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary directly connected to the identified Target Behaviors that are jeopardizing placement and the TBS Treatment Plan. "TBS Collateral" services can be used in such cases when a TBS Coach or TBS Clinical Supervisor contacts the SMHP (Primary Therapist), or Client's Caregivers (Parents, Teacher, Group Home Staff, etc.), as long as it directly relates to the TBS Treatment Plan. As a general rule, if the CONTRACTOR is providing services that are linked to Target Behaviors or TBS Treatment Plan and the beneficiary is not present, then the CONTRACTOR would be delivering "Collateral TBS". An example of "Collateral TBS" would be when the CONTRACTOR is working with the parent/caregiver towards the goals of the child/youth's TBS Treatment Plan, or while conducting a TBS Treatment Team meeting. TBS Collateral contact must be with individuals identified as significant in the child/youth's life and be directly related to the needs, goals and interventions of the child/youth as identified on the TBS Treatment Plan. This services can be delivered either face-to-face or by phone

3. All of these TBS codes are billed at the same CONTRACTOR's TBS rate as established in Schedule I attached. All TBS codes billed must be documented with

a separate progress note per the time of services provided. The total time that can be spent on Assessment and Collateral TBS activities will not exceed 20% of the total hours billed. All time shall be documented in minutes rather than hours or fractions thereof.

CONTRACTOR shall maintain a line item budget and provide quarterly expenditure reports indicating expenditure and revenues compared to the budget. CONTRACTOR is responsible for entering all COUNTY Management Information System data; including service billings, Medi-Cal eligibility information and Client Care/Treatment Plans.

D. CLIENT RECORDS AND DOCUMENTATION:

CONTRACTOR must maintain clinical client records and meet minimum documentation requirements of Coordinated Care/Rehabilitation Option per COUNTY and State policy.

For TBS all documentation (Assessments, Treatment Plans, Progress Notes) in client charts must be consistent with DMH Letter No. 99-03, Section VI, "Client Plan and Documentation Requirements;" consistent with California State DMH TBS Documentation Manual (which can be found on the DMH website at: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/TBS_Documentation_Manual_10_26_09.pdf), and the requirements identified in Title 9, CCR, Division 1, Chapter 11.

1. TBS ASSESSMENT

Consistent with DMH Letter No. 99-03, Section III, "Criteria for Medi-Cal Reimbursement for Therapeutic Behavioral Service", an assessment for specialty mental health services, either focused on TBS or with TBS consideration as a component, must be comprehensive enough to identify that the child/youth meets medical necessity criteria, is a full-scope Medi-Cal beneficiary under 21 years of age, and is a member of the certified class; that there is a need for specialty mental health services in addition to TBS; and that the child/youth has specific behaviors

1 and/or symptoms that require TBS. Concrete identification of behaviors and
2 individualized interventions in the assessment process is the key component
3 necessary to developing an effective TBS Treatment Plan. TBS Assessments must:
4 a. Identify the child/youth's *specific* behaviors and/or symptoms that jeopardize
5 continuation of the current residential placement or the *specific* behaviors and/or
6 symptoms that are expected to interfere when a child/youth is transitioning to a
7 lower level of residential placement.
8 b. Describe the critical nature of the situation, the severity of the child/youth's
9 behaviors and/or symptoms, what other less intensive services have been tried
10 and/or considered, and why these less intensive services are not or would not be
11 appropriate.
12 c. Provide sufficient clinical information to demonstrate that TBS is necessary to
13 sustain the residential placement or to successfully transition to a lower level of
14 residential placement and can be expected to provide a level of intervention
15 necessary to stabilize the child/youth in the existing residential placement or to
16 address behaviors and/or symptoms that jeopardize the child/youth's transition
17 to a lower level of care.
18 d. Identify what changes in behavior and/or symptoms TBS is expected to achieve
19 and how the child/youth's therapist or treatment team will know when these
20 services have been successful and can be reduced or terminated.
21 e. Identify skills and adaptive behaviors that the child/youth is using now to
22 manage problem behavior in other circumstances that could replace the
23 specified problem behaviors and/or symptoms.
24 2. TBS TREATMENT PLAN
25 A TBS Treatment Plan is intended to provide clinical direction for one or a series of
26 short-term intervention(s) to address very specific behaviors and/or symptoms of
27 the child/youth as identified by the assessment process. A clear and specific TBS
28 /

1 Treatment Plan is a key component in ensuring effective delivery of TBS. TBS
2 Treatment Plans must include:
3 a. Clearly specified behaviors and/or symptoms that jeopardize the family home,
4 residential placement or transition to a lower level of residential placement and
5 that will be the focus of TBS.
6 b. A specific individualized plan of intervention for each of the targeted behaviors
7 or symptoms identified in the assessment and the Treatment Plan based on the
8 Functional Analysis of Behavior.
9 c. A specific description of the changes in the behaviors and/or symptoms that the
10 interventions are intended to produce, including a time frame for these changes.
11 d. A specific way to measure the effectiveness of the intervention at regular
12 intervals and documentation of changes in planned interventions when the
13 original plans are not achieving expected results.
14 e. A transition plan that describes in measurable terms how and when TBS will be
15 decreased and ultimately discontinued, either when the identified benchmarks
16 (which are the objectives that are met as the beneficiary progresses towards
17 achieving Treatment Plan goals) have been reached or when reasonable
18 progress towards goals is not occurring and, in the clinical judgment of the
19 individual or treatment team developing the plan, are not reasonably expected to
20 be achieved. This plan should address assisting parents/caregivers with skills
21 and strategies to provide continuity of care when TBS is discontinued.
22 f. As necessary, a plan for transition to adult services when the beneficiary turns
23 21 years old and is no longer eligible for TBS. This plan should also address
24 assisting parents/caregivers with skills and strategies to provide continuity of
25 care when this service is discontinued, when appropriate in the individual case.
26 g. If the TBS beneficiary is between 18 and 21 years of age, notes regarding any
27 special considerations that should be taken into account, e.g., the identification
28 of an adult case manager.

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3. TBS TREATMENT PLAN ADDENDUM

   A Treatment Plan addendum or other mechanism should be used to document the following situations:

   a. There have been significant changes in the child/youth's environment since the initial development of the TBS Treatment Plan.

   b. The TBS provided to the child/youth has not been effective and the child/youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the CONTRACTOR indicating that they have considered alternatives, and only requested additional days for TBS based on the documented expectation that the additional time will be effective.

4. TBS S PROGRESS NOTES

   Progress notes must clearly and specifically document the occurrence of the Target Behaviors. Significant interventions must also be identified and the progress, or lack of progress, that is being made toward the behavioral benchmarks indicated in the TBS Treatment Plan. Documentation continues to be required once each day that TBS is delivered and a separate note for each TBS billing code is required. Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The time of service may be noted by contact/shift. Each TBS Coaching progress note is to indicate the next planned TBS Coaching service date and time and must be counter-signed by a TBS Clinical Supervisor.

5. DISCHARGE

   All discharge documentation is to be completed no later than the final day that TBS is provided. Discharge documentation includes: final Behavioral Analysis Form, sending out Client/Parent Satisfaction Surveys and a final TBS Chart Note.

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E. PROGRAM MONITORING:

The Department of Mental Health will utilize the "Program Monitoring Team Manual" (PMT) as a tool to monitor the services provided by this CONTRACTOR as stipulated in the contract. The monitoring will include all clinical, fiscal and administrative components.

F. OUTCOME MEASURES:

The CONTRACTOR and the COUNTY will work jointly to monitor outcome measures as follows:

1. Seventy percent (70%) of those provided services will remain out of the hospital and not require a higher level of care while receiving services.
2. Behavior Assessment Form (BAF) will be completed monthly and discussed during every Treatment Team meeting as a measurement of progress.
3. Satisfaction Surveys will be provided to the beneficiaries and parent/caregivers upon termination of TBS.

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1 EXHIBIT A-2

2 CONTRACTOR NAME: ***COMMUNITY ACCESS NETWORK, INC.***

3 DEPT. ID/PROGRAM NO: ***4100207246/83550/74700***

4 THERAPEUTIC BEHAVIORAL SERVICES EXHIBIT

5 MODE OF SERVICE	SERVICE FUNCTION
6 MHSA Outpatient Services	Behavioral Coaching Services

7 I. SCOPE OF SERVICES:

8 CONTRACTOR shall provide Behavioral Coaching Services (BCS) as a singular
9 service to minors referred by DMH who receive specialty mental health services paid
10 for by Medi-Cal in other programs. Behavioral Coaching Services (BCS) will be
11 provided through funding from the Mental Health Services Act (MHSA) on a funds-
12 limited basis to non-Medi-Cal recipients. These MHSA BCS clients must otherwise
13 meet Therapeutic Behavioral Services (TBS) criteria as designated in the body of this
14 document as all BCS is modeled after and equivalent to TBS. Throughout this
15 document when reference is made to Medi-Cal (i.e., Medi-Cal funded mental health
16 services, Medi-Cal beneficiaries, etc.) it should be understood as not being limited to
17 Medi-Cal services, for the purpose of these non-Medi-Cal MHSA BCS recipients.

18 A. THERAPEUTIC BEHAVIORAL SERVICES GENERAL DESCRIPTION:

19 CONTRACTOR shall provide Behavioral Coaching Services, where authorized by
20 Mental Health. Behavioral Coaching Services (BCS) are interventions, which may
21 include support for the family, foster family or support system's efforts to provide a
22 positive environment for the child/youth. BCS is intended to supplement other
23 specialty mental health services by addressing the target behavior(s) or symptoms that
24 are jeopardizing the child/youth's current living situation or the planned transition to a
25 lower level of placement. The purpose of providing BCS is to further the child/youth's
26 overall treatment goals by providing additional one on one behavioral intervention
27 services during a short term period. All services must be in compliance with State
28 Department of Mental Health letter #99-03 & other state letters on TBS.

BCS will be decreased when the identified behavioral benchmarks have been reached or when reasonable progress towards the behavioral benchmarks are not being achieved and are not reasonably expected to be achieved in the clinical judgment of the BCS Treatment Team; which is comprised of the child/youth's Specialty Mental Health Provider (SMHP) (i.e., primary case manager and/or therapist), the CONTRACTOR's clinical staff and the parent/caregiver, and COUNTY TBS Liaison. These services are intended to be short-term and not intended to provide childcare or basic supervision or to maintain a child/youth at a specified level for the long term. BCS hours are decreased based on the schedule determined by combined input of the BCS Supervisor, the parent/caregiver, COUNTY TBS Liaison and SMHP.

CONTRACTOR must be able to provide services any time of the day, seven (7) days a week as needed to address specific service plans.

B. TARGET POPULATION TO BE SERVED:

The primary target population for BCS, which is funded under the Mental Health Services Act (MHSA) on a funds-limited basis to non-Medi-Cal recipients who must be under 18 years old, meet the Mental Health Plan medical necessity criteria, are receiving other non-Medi-Cal funded mental health services from a Riverside County Clinic, currently residing in a family home/long term guardianship placement and are highly likely, without BCS, to be at risk of placement at a higher level of residential care or hospitalization. These MHSA BCS clients must otherwise meet TBS criteria as previously indicated.

C. CONTRACTOR RESPONSIBILITIES:

The CONTRACTOR must be a certified Medi-Cal provider and is responsible for all aspects of TBS and BCS. The CONTRACTOR shall hire, train and supervise staff. Existing staff may be utilized for this purpose; however, BCS supervisor and staff should be distinct from group home staff to facilitate the separation between BCS and Group Home services (if applicable). They also shall document and bill the service, and report the costs associated with the service to the COUNTY for reimbursement.

1 The CONTRACTOR is expected to follow all of the usual procedures and policies as in
2 any other Medi-Cal funded service including case documentation.
3 Additional responsibilities are as follows:

1. CONTRACTOR shall be prepared to provide BCS at off-site facilities as appropriate, including the group home, client's home, foster home or community.
2. Identify a BCS clinical supervisor and back up, both of which must be Licensed in California as a Licensed Practitioner of the Healing Arts (LPHA), who shall also act as liaison with the COUNTY of Riverside and oversee the CONTRACTOR's BCS program and staff. This individual shall take all referrals, ensure completion of the BCS Assessment including a Functional Analysis of Behavior (FAB) for each target behavior, assign and supervise staff. Each CONTRACTOR must develop and submit to the COUNTY their own rationale for establishing Supervisory caseloads maximums and ensure staff is hired in a timely manner to meet stated maximums. Please see COUNTY recommendation for TBS Supervisory Caseload Guidelines.
3. CONTRACTOR shall complete an initial, monthly and discharge Behavioral Assessment Form (BAF) on each BCS case they serve and submit them monthly to the COUNTY for data processing, while maintaining a copy of each BAF in the BCS chart. Monthly BAFs and Monitoring Tools are to be completed for each BCS Treatment Team Meeting.
4. Provide education and training to BCS staff on a regular basis and make staff available to attend required training related to the provision of BCS.
5. Ensure required BCS Treatment Team planning meetings occur with BCS Liaison and BCS staff participates in consultation as determined by current county policy.
6. Ensure BCS staff provides a minimum of bi-weekly feedback to the SMHP regarding the status of BCS, and document progress of BCS Treatment Plan interventions and continued client needs.
7. Ensure appropriate documentation occurs which meets Medi-Cal standards.

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8. Ensure that all treatment plans are signed by the Client, Caregiver, BCS Clinical Supervisor, SMHP, and BCS Coach. Any exception to obtaining one of these signatures should have a corresponding note in the Client's chart.
9. Audit BCS charts on a regular basis as evidenced by BCS Clinical Supervisor's signature on each billed progress note.
10. Track hours billed against hours worked and progress notes submitted.
11. CONTRACTOR shall develop an intervention plan, identify specific target behavior(s), proposed hours, and proposed times of services. The CONTRACTOR shall coordinate services with the child/youth's SMHP and family.
12. Cooperate with COUNTY contract monitoring team for monthly, quarterly and annual reviews.
13. CONTRACTOR shall respond to referrals within two (2) business days. If CONTRACTOR is unable to establish contact with BCS Treatment Team members within the first week and set the initial Treatment Team meeting date within three weeks of the receipt of the BCS Referral, then CONTRACTOR is to notify the COUNTY BCS Liaison and document the notification.
14. Notify COUNTY in writing of any special incidents (injury, altercations, etc.) occurring during the delivery of BCS.

CONTRACTOR shall remain a Medi-Cal certified provider.

D. STAFFING:

BCS shall be provided by licensed staff, trained unlicensed Board of Behavioral Sciences registered or paraprofessional staff members who are under the direction of a licensed clinician. BCS providers must meet the organizational provider qualifications already established in Title 9, CCR, Section 1810.435. In addition, both individuals who assess beneficiaries to determine the need for BCS and individuals who provide direct BCS interventions must meet the requirements of the Judgment and Permanent Injunction in Emily Q. v. Bontá, which requires that TBS providers have training in

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behavior analysis with an emphasis on positive behavioral interventions. The BCS staff person must be available at the designated site of service to:

1. Provide structure and support.
2. Assist the child/youth in engaging in appropriate activities.
3. Minimize impulsivity.
4. Increase social and community competencies by building or reinstating those daily living skills that will assist the child/youth to live successfully in the community.
5. Implement interventions identified in the BCS Treatment Plan with the client and Caregivers, modeling and guiding them in their use of these interventions.

The BCS staff also serves as a positive role model and assists in developing the child/youth's ability to sustain self-directed appropriate behavior, internalize a sense of social responsibility, and/or enable participation proactively in community activities. BCS staff must be available to participate in weekly/monthly conference calls and provide feedback on progress of the intervention and continued client needs.

E. <u>COORDINATION BETWEEN BCS AND OTHER SERVICES:</u>

MHSA BCS is provided to children/youth who are receiving mental health services from Riverside County Mental Health Clinic and are non-Medi-Cal beneficiaries. Therefore, there is a potential for the child/youth to be receiving BCS at the same time and location that the child/youth is participating in other programs. All specialty mental health services, including BCS, must provide a clear audit trail and be identified as the appropriate intervention necessary to support the beneficiary's efforts in attaining the objectives necessary to achieving the goals of their Treatment Plan(s).

1. The role of the staff providing BCS is to implement the BCS Treatment Plan by providing the interventions addressing the specific problem behaviors and/or symptoms BCS is intended to resolve.
2. BCS is provided face-to-face by one provider to the child/youth for whom the services are authorized.

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3. BCS involves individualized proactive interventions, not general supervision per DMH Information Notice 02-08.
4. BCS must be provided in a manner that decreases the need for BCS and should not foster dependency.
5. BCS staff providing BCS to a child/youth for specified hour may not provide BCS to another child/youth during that same time frame, as BCS is a one-to-one service.
6. Transporting a child/youth is not a reimbursable BCS activity. Accompanying a child/youth who is being transported may be reimbursable, depending on the specific circumstances.
7. Staff providing BCS are not authorized to provide seclusion or restraint.
8. BCS must be clearly differentiated from other mental health services as stabilizing a situation in which a child/youth is at risk of placement in an RCL 12 to 14 group home, or locked facility for the treatment of mental health needs, or to enable transition from any of those levels to a lower level of residential care.

It is expected that the direct BCS provider would have contact with the child/youth's parents/caregivers. The BCS provider would be delivering "Collateral BCS" when working with the parent/caregiver towards the goals of the child/youth's BCS Treatment Plan. Direct BCS providers making use of Collateral BCS activities must ensure that the collateral contact meets the requirements of Title 9, CCR, Sections 1810.206 and 1840.314. The contact must be with individuals identified as significant in the child/youth's life and must be directly related to the needs, goals and interventions of the child/youth as identified on the BCS Treatment Plan and documented as such.

II. ADMINISTRATIVE

A. COUNTY'S RESPONSIBILITY:

1. Make referrals of clients to CONTRACTOR using established procedures.
2. Provide CONTRACTOR with initial and on-going payment authorizations of BCS upon request in accordance with COUNTY procedure, DMH Information Notice

1 02-08 and DMH Letter 04-02 and 04-03.

2 3. Coordinate any COUNTY operated therapy services with BCS services.

3 4. Assist in problem solving issues around clients and programs.

4 B. <u>AUTHORIZATION PROCESS FOR BCS:</u>

5 Authorization procedures are to be made in compliance with current DHM Information

6 Letters and Notices.

7 1. CONTRACTOR is required to request service authorization for BCS in advance of

8 the delivery of the services included in the authorization request.

9 2. The initial service authorization may not exceed 30 days. The initial authorization

10 will cover the CONTRACTOR conducting an initial BCS Assessment with a FAB,

11 which must identify at least one symptom or behavior, along with the function it

12 serves that BCS will address; developing an initial BCS Treatment Plan, which

13 must identify at least one unique BCS intervention linked specifically to the

14 strengths or interests of that client and serve the same function of the behavior to be

15 replaced; complete the Behavior Assessment Form; and providing the initial

16 delivery of direct one-to-one BCS once BCS Assessment is completed.

17 3. All identified MHSA BCS cases will be allotted a maximum of 300 hours for the

18 entire service period. Per MHSA BCS authorization procedure services cannot be

19 reauthorized after the 300 hours has been exhausted.

20 4. When the CONTRACTOR received an initial authorization for 30 days, the

21 CONTRACTOR'S first request for reauthorization must include a BCS Treatment

22 Plan that meets the criteria specified in the "BCS Client Plans" section of DMH

23 Information Notice 02-08.

24 5. When the CONTRACTOR'S initial request for COUNTY service authorization has

25 concluded, upon receipt of BCS Assessment with a FAB, initial BCS Treatment

26 Plan, and Behavior Assessment Form; the COUNTY may reauthorize BCS if fully

27 supported by the above-mentioned items. Reauthorizations may be approved for 60

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1 days with the exception of MHSA BCS cases. All MHSA BCS reauthorizations
2 may be approved for a maximum of 30 days.
3 6. Reauthorizations must be based upon clear documentation of the following and any
4 additional information from the BCS provider required by the COUNTY:
5 a. The child/youth's progress towards the specific goals and timeframes of the
6 BCS Treatment Plan. A strategy to decrease the intensity of services and/or to
7 initiate the transition plan and/or terminate services when BCS has been
8 effective for the child/youth in making progress towards specified measurable
9 outcomes identified in the BCS plan or the child/youth has reached a plateau in
10 benefit effectiveness.
11 b. If applicable, the child/youth's lack of progress towards the specific goals and
12 timeframes of the BCS Treatment Plan and changes need to be addressed.
13 c. If the BCS being provided to the child/youth has not been effective and the
14 child/youth is not making progress as expected towards identified goals, then
15 alternatives must be considered. If BCS is going to be continued then the
16 rational for continuing BCS must be clearly identified.
17 d. Significant changes in the child/youth's environment must be reviewed and any
18 updates necessary must be added to the BCS Treatment Plan (e.g., a change in
19 residence).
20 e. The progress and provision of skills and strategies being provided to
21 parents/caregivers to ensure continuity of care when BCS is discontinued.
22 C. ADMINISTRATIVE:
23 CONTRACTOR will be reimbursed for all time spent providing the direct services plus
24 travel and documentation time. Supervision of CONTRACTOR's BCS staff and
25 liaison time with the COUNTY is an indirect cost that must be included in the per
26 minute rate, as they are not direct Medi-Cal or MHSA BCS reimbursable services.
27 1. Items will be recouped for the following reasons:
28 a. MHSA BCS cases exceeding 300 hours of service.

b. No progress note was found for service claimed in accordance with DMH Letter No. 99-03, pages 6-7.

c. No documentation of a plan for BCS in accordance with DMH Letter No. 99-03, pages 6-7.

d. Per DMH Letter No. 99-03, page 4; progress notes clearly indicate that BCS was provided solely for one of the following reasons:

   1) For the convenience of the family, caregivers, physician, or teacher.

   2) To provide supervision or to ensure compliance with terms and conditions of probation.

   3) To ensure the child/youth's physical safety or the safety of others, e.g., suicide watches.

   4) To address conditions which are not a part of the child/youth's mental health condition.

e. The progress note clearly indicates that BCS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility in accordance with DMH Letter No. 99-03, page 5.

f. The progress note clearly indicates that BCS was provided to a beneficiary in juvenile hall and when ineligible for Medi-Cal; per CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9).

g. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for FFP, e.g., Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per Title 9, Chapter 11 (CCR, Title 9, Chapter 11, Sections 1840.312(g)&(h) and 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273(1-9)).

2. All MHSA BCS cases have a single procedure code of (399), though the same services are required as with TBS. For TBS the services are separated into three categories: TBS (394) Coach Time (face-to-face), TBS – Assessment (395), & TBS

– Collateral (396). All MHSA BCS cases have the same services required (Coach Time, Assessment and Collateral), however there is a single procedure code of (399) billed for all three services. The procedure codes and service definitions of service are as follows:

a. TBS Coach Time (394) or MHSA BCS Coach Time (399) – Therapeutic Behavioral Services are a one-to-one (face-to-face) therapeutic contract between a mental health provider (TBS Coach/BCS Coach) and a beneficiary for a specified short-term period of time, which is designed to maintain the child/youth's placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals.
    1) Coach Time may not begin until the initial Assessment is completed.
    2) The majority of billing should fall under this category.
b. TBS – Assessment (395) or BSC Assessment (399) – A service activity conducted by the TBS/BCS Clinical Supervisor, or under the TBS/BCS Clinical Supervisor's direction by a Board of Behavioral Sciences registered Marriage and Family Therapist (MFT) Intern, or registered Licensed Clinical Social Worker (LCSW) Associate, which must include the FAB and the initial BAF based on information gained through consultation with Specialty Mental Health Service Provider, Parent/Caregiver and Beneficiary. The Assessment must focus on identifying the child/youth's Target Behaviors and/or symptoms that jeopardize continuation of the current residential placement or that are expected to interfere when a child/youth is transitioning to a lower level of residential placement. BCS Assessment service activity will include BCS Assessment and BCS Treatment Plan development time. This service is not always a direct face-to-face service. An Assessment may include the following: a clinical analysis of the history and current status of a beneficiary's mental, emotional, or behavioral disorder; relevant cultural and environmental issues; and diagnosis.

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1) Documentation to be completed is the FAB for each of the identified Target Behaviors that are jeopardizing placement, initial BAF and a BCS Treatment Plan.

c. TBS – Collateral (396) or BSC Collateral (399) – A service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary directly connected to the identified Target Behaviors that are jeopardizing placement and the BCS Treatment Plan. "BCS Collateral" services can be used in such cases when a BCS Coach or BCS Clinical Supervisor contacts the SMHP (Primary Therapist), or Client's Caregivers (Parents, Teacher, Group Home Staff, etc.), as long as it directly relates to the BCS Treatment Plan. As a general rule, if the CONTRACTOR is providing services that are linked to Target Behaviors or BCS Treatment Plan and the beneficiary is not present, then the CONTRACTOR would be delivering "Collateral BCS". An example of "Collateral BCS" would be when the CONTRACTOR is working with the parent/caregiver towards the goals of the child/youth's BCS Treatment Plan, or while conducting a BCS Treatment Team meeting. BCS Collateral contact must be with individuals identified as significant in the child/youth's life and be directly related to the needs, goals and interventions of the child/youth as identified on the BCS Treatment Plan. This services can be delivered either face-to-face or by phone

3. All of these BCS codes are billed at the same CONTRACTOR's BCS rate as established in Schedule I attached. All BCS codes billed must be documented with a separate progress note per the time of services provided. The total time that can be spent on Assessment and Collateral BCS activities will not exceed 20% of the total hours billed. All time shall be documented in minutes rather than hours or fractions thereof.

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CONTRACTOR shall maintain a line item budget and provide quarterly expenditure reports indicating expenditure and revenues compared to the budget. CONTRACTOR is responsible for entering all COUNTY Management Information System data; including service billings, Medi-Cal eligibility information and Client Care/Treatment Plans.

D. CLIENT RECORDS AND DOCUMENTATION:

CONTRACTOR must maintain clinical client records and meet minimum documentation requirements of Coordinated Care/Rehabilitation Option per COUNTY and State policy.

For BCS all documentation (Assessments, Treatment Plans, Progress Notes) in client charts must be consistent with DMH Letter No. 99-03, Section VI, "Client Plan and Documentation Requirements;" consistent with California State DMH TBS Documentation Manual (which can be found on the DMH website at: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/TBS_Documentation_Manual_10_26_09.pdf), and the requirements identified in Title 9, CCR, Division 1, Chapter 11.

1. BCS ASSESSMENT

   Consistent with DMH Letter No. 99-03, Section III, "Criteria for Medi-Cal Reimbursement for Therapeutic Behavioral Service", an assessment for specialty mental health services, either focused on BCS or with BCS consideration as a component, must be comprehensive enough to identify that the child/youth meets medical necessity criteria, is under 18 years of age, and is a member of the certified class; that there is a need for specialty mental health services in addition to BCS; and that the child/youth has specific behaviors and/or symptoms that require BCS. Concrete identification of behaviors and individualized interventions in the assessment process is the key component necessary to developing an effective BCS Treatment Plan. BCS Assessments must:

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a. Identify the child/youth's *specific* behaviors and/or symptoms that jeopardize continuation of the current residential placement or the *specific* behaviors and/or symptoms that are expected to interfere when a child/youth is transitioning to a lower level of residential placement.

b. Describe the critical nature of the situation, the severity of the child/youth's behaviors and/or symptoms, what other less intensive services have been tried and/or considered, and why these less intensive services are not or would not be appropriate.

c. Provide sufficient clinical information to demonstrate that BCS is necessary to achieve the goal of keeping the child/youth in the family home.

d. Identify what changes in behavior and/or symptoms BCS is expected to achieve and how the child/youth's therapist or treatment team will know when these services have been successful and can be reduced or terminated.

e. Identify skills and adaptive behaviors that the child/youth is using now to manage problem behavior in other circumstances that could replace the specified problem behaviors and/or symptoms.

2. BCS TREATMENT PLAN

A BCS Treatment Plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the child/youth as identified by the assessment process. A clear and specific BCS Treatment Plan is a key component in ensuring effective delivery of BCS. BCS Treatment Plans must include:

a. Clearly specified behaviors and/or symptoms that jeopardize the family home, residential placement or transition to a lower level of residential placement and that will be the focus of BCS.

b. A specific individualized plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the Treatment Plan based on the Functional Analysis of Behavior.

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c. A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.

d. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

e. A transition plan that describes in measurable terms how and when BCS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving Treatment Plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when BCS is discontinued.

f. As necessary, a plan for transition to adult services when the beneficiary turns 18 years old and is no longer eligible for BCS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

3. BCS TREATMENT PLAN ADDENDUM

A Treatment Plan addendum or other mechanism should be used to document the following situations:

a. There have been significant changes in the child/youth's environment since the initial development of the BCS Treatment Plan.

b. The BCS provided to the child/youth has not been effective and the child/youth is not making progress as expected towards identified goals. In this situation, there must be documented evidence in the chart and any additional information from the CONTRACTOR indicating that they have considered alternatives, and only requested additional days for BCS based on the documented expectation that the additional time will be effective.

4. BCS S PROGRESS NOTES

Progress notes must clearly and specifically document the occurrence of the Target Behaviors. Significant interventions must also be identified and the progress, or lack of progress, that is being made toward the behavioral benchmarks indicated in the BCS Treatment Plan. Documentation continues to be required once each day that BCS is delivered and a separate note for each BCS billing code is required. Progress notes must include a comprehensive summary covering the time that services were provided, but need not document every minute of service time. The time of service may be noted by contact/shift. Each BCS Coaching progress note is to indicate the next planned BCS Coaching service date and time and must be counter-signed by a BCS Clinical Supervisor.

5. DISCHARGE

All discharge documentation is to be completed no later than the final day that BCS is provided. Discharge documentation includes: final Behavioral Analysis Form, sending out Client/Parent Satisfaction Surveys and a final BCS Chart Note.

E. PROGRAM MONITORING:

The Department of Mental Health will utilize the "Program Monitoring Team Manual" (PMT) as a tool to monitor the services provided by this CONTRACTOR as stipulated in the contract. The monitoring will include all clinical, fiscal and administrative components.

F. OUTCOME MEASURES:

The CONTRACTOR and the COUNTY will work jointly to monitor outcome measures as follows:

1. Seventy percent (70%) of those provided services will remain out of the hospital and not require a higher level of care while receiving services.
2. Behavior Assessment Form (BAF) will be completed monthly and discussed during every Treatment Team meeting as a measurement of progress.

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3. Satisfaction Surveys will be provided to the beneficiaries and parent/caregivers upon termination of BCS.

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EXHIBIT C

REIMBURSEMENT & PAYMENT

CONTRACTOR NAME: **COMMUNITY ACCESS NETWORK, INC.**

A. REIMBURSEMENT:

1. In consideration of services provided by CONTRACTOR pursuant to this Agreement, CONTRACTOR shall receive monthly reimbursement based upon the unit rate as specified in the Schedule I and actual units provided, less revenue collected, , not to exceed the maximum obligation of the COUNTY as specified herein. Schedule I is attached hereto and incorporated herein by this reference.

2. The final year-end settlement for non Medi-Cal services shall be based on the Actual Cost, multiplied by the actual number of units, less revenue collected. The final year-end settlement for Medi-Cal services shall be based on final State approved Medi-Cal units, multiplied by the actual allowable cost per unit of services provided, the State Maximum Allowance (SMA) rate, or customary charges, whichever is lower, less revenue collected. The combined final year-end settlement for Medi-Cal and non Medi-Cal services shall not exceed the maximum obligation of the COUNTY as specified herein, and the applicable maximum reimbursement rates promulgated each year by the State.

B. MEDI-CAL RATES:

The CONTRACTOR acknowledges Medi-Cal rates are subject to annual adjustments mandated by the State.

C. MAXIMUM OBLIGATION:

COUNTY'S maximum obligation for fiscal year 2011/2012 shall be $699,999, subject to availability of Federal, State, and local funds.

D. BUDGET:

Schedule I presents (for budgetary and planning purposes only) the budget details pursuant to this Agreement. Where applicable, Schedule I contains department identification number (dept. id), billable and non-billable codes, the reporting unit (RU), the mode(s) of service, the service functions, units, revenues received, maximum obligation and source of funding pursuant to this Agreement.

E. SHORT-DOYLE/MEDI-CAL (SD/MC):

1. With respect to services provided to Medi-Cal beneficiaries, CONTRACTOR shall comply with applicable Medi-Cal cost containment principles where reimbursement is based on actual allowable cost, approved Medi-Cal rate, State approved negotiated SD/MC rate or customary charges, whichever is lower as specified in Title 19 of the Social Security Act, Title 22 of the California Code of Regulations and policy letters issued by the State Department of Mental Health.

2. SD/MC reimbursement is composed of Local Matching Funds and Federal Financial Participation (FFP).

F. REVENUES:

1. Pursuant to the provisions of Sections 4025, 5717 and 5718 of the Welfare & Institutions Code, and as further contained in the State Department of Mental Health Revenue Manual, Section 1, CONTRACTOR shall collect revenues for the provision of the services described pursuant to Exhibit A. Such revenues may include but are not limited to, fees for services, private contributions, grants or other funds. All revenues received by CONTRACTOR shall be reported in their annual Cost Report, and shall be used to offset gross cost.

1 2. Patient/client eligibility for reimbursement from Medi-Cal, Private Insurance,
2 Medicare, or other third party benefits shall be determined by the
3 CONTRACTOR. CONTRACTOR shall pursue payment from all potential
4 sources in sequential order, with Short/Doyle Medi-Cal as payor of last resort.
5 CONTRACTOR is to attempt to collect first from Medicare (if site is Medicare
6 certified), then insurance and then first party. In addition, CONTRACTOR is
7 responsible for adhering to and complying with all applicable Federal, State
8 and local Medi-Cal and Medi-Care laws and regulations as it relates to
9 providing services to Medi-Cal and Medi-Care beneficiaries.
10 3. If a client has both Medicare or insurance and Medi-Cal coverage, a copy of
11 the Medicare or insurance Explanation of Benefits (EOB) must be provided to
12 the COUNTY within thirty (30) days of receipt.
13 4. CONTRACTOR is obligated to collect from the client any Medicare co-
14 insurance and/or deductible if the site is Medicare certified. CONTRACTOR
15 is required to clear any Medi-cal Share of Cost amount (s) with the State.
16 CONTRACTOR is obligated to attempt to collect the cleared Share of Cost
17 amount (s) from the client. CONTRACTOR must notify the COUNTY in
18 writing of cleared Medi-Cal Share of Cost (s) within seventy two (72) hours
19 (excluding holidays) of the CONTRACTOR'S received notification from the
20 State. Patients/clients with share of cost Medi-Cal shall be charged their
21 monthly Medi-Cal share of cost in lieu of their annual liability. Medicare
22 clients will be responsible for any co-insurance and/or deductible for services
23 rendered at Medicare certified sites.
24 5. All other clients will be subject to an annual sliding fee schedule by
25 CONTRACTOR for services rendered, based on the patient's/client's ability to
26 pay, not to exceed the CONTRACTOR'S actual charges for the services
27 provided. In accordance with the State Department of Mental Health's
28 Revenue Manual, CONTRACTOR shall not be penalized for non-collection of

revenues provided that reasonable and diligent attempts are made by the CONTRACTOR to collect these revenues. Past due patient/client accounts may not be referred to private collection agencies. No patient/client shall be denied services due to inability to pay.

6. CONTRACTOR shall submit to COUNTY, with signed contract, a copy of CONTRACTOR'S published charges.

7. If CONTRACTOR charges the client any additional fees (i.e. Co-Pays) above and beyond the Contracted Schedule I rate, the CONTRACTOR must notify the COUNTY within ten (10) days of signing the AGREEMENT.

8. CONTRACTOR must notify the COUNTY if CONTRACTOR raises client fees. Notification must be made within ten (10) days following any fee increase.

G. REALLOCATION OF FUNDS:

1. No funds allocated for any Mode of Service as designated in Schedule I may be reallocated to another Mode of Service unless written approval is given by the Program Manager prior to either the end of the Contract Period of Performance or the end of the Fiscal year (June 30th). Approval shall not exceed the maximum obligation

2. In addition, CONTRACTOR may not, under any circumstances and without prior approval and/or written consent from the Region/Program Manager/Administrator and confirmation from by the Supervisor of the COUNTY Fiscal Unit, reallocate funds between non-billable and billable mode and service functions and/or service procedure codes as designed in the Schedule I that are defined as non-billable by the COUNTY, State or Federal governments from or to funds, services, mode of services and/or procedure codes that are defined as billable by the COUNTY, State or Federal governments.

3. If this Agreement includes more than one Exhibit C, shifting of funds from one Exhibit C to another is also prohibited without prior, written consent and

approval from the Region Program Manager/Administrator prior to the end of either the Contract Period of Performance or Fiscal year.

H. RECOGNITION OF FINANCIAL SUPPORT:

If, when and/or where applicable, CONTRACTOR'S stationery/letterhead shall indicate that funding for the program is provided in whole or in part by the COUNTY of Riverside Department of Mental Health.

I. PAYMENT:

1. Monthly reimbursements may be withheld at the discretion of the Director or its designee due to material contract non-compliance, including audit disallowances invoice or contract overpayment and/or adjustments or disallowances resulting from the COUNTY Contract Monitoring Review (CMT), Program Monitoring and/or the Cost Report Reconciliation/Settlement process.

2. In addition, if the COUNTY determines that there is any portion (or all) of the CONTRACTOR invoice(s) that cannot be substantiated, verified or proven to be valid in any way for any fiscal year, then the COUNTY reserves the right to disallow and/or withhold current and/or future payments from CONTRACTOR until valid, substantial proof of any and/or all items billed for is received, verified and approved by the COUNTY.

3. In addition to the CMT, Program Monitoring, and Cost Report Reconciliation/Settlement processes, the COUNTY reserves the right to perform periodic service deletes and denial monitoring for this agreement throughout the fiscal year in order to minimize and/or potentially prevent COUNTY and CONTRACTOR loss. The COUNTY, at its discretion, may withhold and/or offset invoices and/or monthly reimbursements to CONTRACTOR, at any time without prior notification to CONTRACTOR, for service deletes and denials that may occur in association with this agreement. COUNTY shall notify CONTRACTOR of any such instances of services deletes and denials and

subsequent withholds and/or reductions to CONTRACTOR invoices or monthly reimbursements.

4. Notwithstanding the provisions of Paragraph I-1 and I-2 above, CONTRACTOR shall be paid in arrears based upon the actual units of services provided and entered into the COUNTY'S specified Electronic Management of Records (ELMR) system. CONTRACTOR will be responsible for entering all client data into the COUNTY's ELMR Provider Connect system on a monthly basis and approving their services in the ELMR Provider Connect system for electronic notification to the COUNTY for batching (invoicing) and subsequent payment. CONTRACTOR must also submit to the COUNTY a signed Program Integrity Form (PIF) signed by the Director of the CONTRACTOR organization or an authorized designee of the CONTRACTOR organization. This form must be faxed and/or emailed (PDF format only) to the COUNTY at fax: (951) 955-7361 and/or emailed to ELMR_PIF@rcmhd.org. The CONTRACTOR PIF form must be received by the COUNTY via fax and/or email for the prior month no later than 5:00 p.m. on the fifth (5th) working day of the current month. Failure by the CONTRACTOR to enter and approve all applicable services into the ELMR system for the applicable month, and faxing and/or emailing the signed PIF, will delay payment to the CONTRACTOR until the required documents as outlined herein are provided. SD/MC billings shall be processed by the COUNTY and the CONTRACTOR shall provide the COUNTY with all information necessary for the preparation and audit of such billings.

5. The CONTRACTOR shall work with the COUNTY to generate a monthly invoice for payment (through the ELMR system batching process) and the COUNTY will work with the CONTRACTOR to access data in the ELMR system for the CONTRACTOR to provide a quarterly report to their designated

COUNTY Region/Program describing outcomes, and progress updates and services delivered based upon the contracts Exhibit A "Scope of Work".

6. Unless otherwise notified by the COUNTY, CONTRACTOR invoicing will be paid by the COUNTY thirty (30) calendar days after the date the PIF is received and invoice is generated by the applicable COUNTY Region/Program.

J. COST REPORT:

1. For each fiscal year, or portion thereof, that this Agreement is in effect, CONTRACTOR shall provide to COUNTY two (2) copies, per each Reporting Unit (RU) number, an annual Cost Report with an accompanying financial statement and applicable supporting documentation to reconcile to the Cost Report within forty-six (46) calendar days following the end of each fiscal year (June 30th), the expiration or termination of the contract, whichever occurs first. The Cost Report shall detail the actual cost of services provided. The Cost Report shall be provided in the format and on forms provided by the COUNTY.

2. CONTRACTOR shall follow all applicable Federal, State and local regulations and guidelines to formulate proper cost reports, including but not limited to OMB-circular A-122, OMB-circular A87, etc. .

3. It is mandatory that the CONTRACTOR send one representative to the cost report training annually that is held by COUNTY that covers the preparation of the year-end Cost Report. The COUNTY will notify CONTRACTOR of the date(s) and time(s) of the training. Attendance at the training is mandatory annually in order to ensure that the Cost Reports are completed appropriately. Failure to attend this training may result in delay of payment to the CONTRACTOR.

4. CONTRACTOR will be notified in writing by COUNTY, if the Cost Report has not been received within forty-five (45) calendar days after the end of the COUNTY Fiscal year. If the Cost Report is not postmarked in the forty-five (45) calendar day time frame, future monthly reimbursements will be withheld

until the COUNTY is in possession of a completed cost report. Future monthly reimbursements will be withheld if the Cost Report contains errors that are not corrected within ten (10) calendar days of written or verbal notification from the COUNTY. Failure to meet any pre-approved deadlines extension will immediately result in the withholding of future monthly reimbursements.

5. The Cost Report shall serve as the basis for year-end settlement to CONTRACTOR including a reconciliation and adjustment of all payments made to CONTRACTOR and all revenue received by CONTRACTOR. Any payments made in excess of Cost Report settlement shall be repaid upon demand, or will be deducted from the next payment to CONTRACTOR.

6. All current and/or future payments to CONTRACTOR will be withheld by the COUNTY until all final, current and prior year Cost Report (s) have been reconciled, settled and signed by CONTRACTOR, and received and approved by the COUNTY.

7. CONTRACTOR shall report Actual Costs separately, if deemed applicable and as per CONTRACTOR Schedule I, to provide Contract Client Services, Prescriptions, Health Maintenance Costs, and Flexible funding costs under this agreement on the annual cost report. Where deemed applicable, Actual Costs for Indirect Administrative Expenses shall not exceed the percentage of cost as submitted in the CONTRACT Request for Proposal or Cost Proposal(s).

K. BANKRUPTCY:

Within five (5) calendar days of filing for bankruptcy, CONTRACTOR shall notify County's Department of Mental Health's Fiscal Services Unit, by certified letter with a courtesy carbon copy to the Department of Mental Health's Program Support Unit, in writing of such. The CONTRACTOR shall submit a properly prepared Cost Report in accordance with requirements and deadlines set forth in Section J before final payment is made.

L. AUDITS:

1. CONTRACTOR agrees that any duly authorized representative of the Federal Government, the State or COUNTY shall have the right to audit, inspect, excerpt, copy or transcribe any pertinent records and documentation relating to this Agreement or previous Agreements in previous years.

2. If this contract is terminated in accordance with Section XXIX, TERMINATION PROVISIONS, COUNTY, Federal and/or State governments may conduct a final audit of the CONTRACTOR. Final reimbursement to CONTRACTOR by COUNTY shall not be made until all audit results are known and all accounts are reconciled. Revenue collected by CONTRACTOR during this period for services provided under the terms of this Agreement will be regarded as revenue received and deducted as such from the final reimbursement claim.

3. Any audit exception resulting from an audit conducted by any duly authorized representative of the Federal Government, the State or COUNTY shall be the responsibility of the CONTRACTOR. Any audit disallowance adjustments may be paid in full upon demand or withheld at the discretion of the Director of Mental Health against amounts due under this Agreement or Agreement(s) in subsequent years.

4. The COUNTY will conduct Program Monitoring Review and/or Contract Monitoring Review (CMT). Upon completion of monitoring, Contractor will be mailed a report summarizing the results of the site visit. A corrective Action Plan will be submitted by CONTRACTOR within thirty (30) calendar days of receipt of the report. CONTRACTOR'S failure to respond within thirty (30) calendar days will result in withholding of payment until the corrective plan of action is received. CONTRACTOR'S response shall identify time frames for implementing the corrective action. Failure to provide adequate response or documentation for this or previous year's

Agreements may result in contract payment withholding and/or a disallowance to be paid in full upon demand.

M. DATA ENTRY:

1. CONTRACTOR understands that as the COUNTY implements its current ELMR system to comply with Federal, State and/or local funding and service delivery requirements, CONTRACTOR will, therefore, be responsible for sending at least one representative to receive all applicable COUNTY training associated with, but not limited to, applicable service data entry, client registration, billing and invoicing (batching), and learning how to appropriately and successfully utilize and/or operate the current and/or upgraded ELMR system as specified for use by the COUNTY under this agreement. The COUNTY will notify the CONTRACTOR when such training is required and available.

2. CONTRACTOR is required to enter all units of service into the COUNTY'S ELMR system for the prior month no later than 5:00 p.m. on the fifth (5th) working day of the current month. Late entry of services into the COUNTY'S ELMR system may result in financial and/or service denials and/or disallowances to the CONTRACTOR.

/Rev. 05/17/10stl; Rev. 06/08/11 stl

SCHEDULE I
MENTAL HEALTH

AMENDMENT 1

CONTRACT PROVIDER NAME: COMMUNITY ACCESSS FISCAL YEAR: 11/12

NEGOTIATED RATE ( ) ACTUAL COST (X) NEGOTIATED NET AMOUNT ( )

CENTRAL CHILDREN SERVICES DEPT. ID/PROGRAM: 4100207246/3550/530280

	TBS	MHSA TBS			TOTAL	
MODE OF SERVICE:	15	15				
SERVICE FUNCTION:	58	57				
RU Number	33JF02	33JFNC				
Procedure Codes	394, 395, 396	394, 395, 396				
NUMBER OF UNITS	382,857	17,142				
COST PER UNIT:	$1.75	$1.75				
GROSS COST:	$670,000	$29,999	$0		699,999	
LESS REVENUES COLLECTED BY CONTRACTORS:						
A. PATIENT FEES						
B. PATIENT INSURANCE						
C. OTHER						
TOTAL CONTRACTOR REVENUES						
LESS MEDI-CAL/FFP						
MAXIMUM OBLIGATION	**670,000**	**29,999**	**0**	**0**	**699,999**	
SOURCES OF FUNDING FOR MAXIMUM OBLIGATION:						%
A. MEDI-CAL/FFP/FEDERAL SHARE	335,000				**335,000**	47.86%
B. REALIGNMENT FUNDS					**0**	
C. STATE GENERAL FUNDS						
D. COUNTY FUNDS					**0**	
E. MEDI-CAL MATCHING FUNDS:						
1. ______________	335,000				**335,000**	47.86%
2. ______________					**0**	
F. OTHER: MHSA		29,999			**29,999**	4.29%
TOTAL (SOURCES OF FUNDING)	$670,000	$29,999	$0	$0	**$699,999**	100.00%

FUNDING SOURCES DOCUMENT: ______________________________

STAFF ANALYST SIGNATURE: DATE: 12/8/11

FISCAL SERVICES SIGNATURE: DATE: 12/14/11