AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND TELECARE CORPORATION

AMENDMENT TO THE AGREEMENT, entered into this _____ day of _____, 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and TELECARE CORPORATION, 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 on October 8, 2019 for full service partnership services, for the term July 1, 2019 through June 30, 2021, in an amount not to exceed $11,662,328; and

WHEREAS, the parties wish to amend the agreement for a new lease agreement, increasing the maximum amount by $432,317 to a new maximum of $12,094,645 with no change to the agreement term.

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 herein and in Exhibit "A2," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B2." The County reserves the right to withhold payment if the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed TWELVE MILLION NINETY-FOUR THOUSAND SIX HUNDRED FORTY-FIVE DOLLARS ($12,094,645).

2. Exhibit A1 is hereby deleted and replaced with Exhibit A2 attached hereto.

3. Exhibit B1 is hereby deleted and replaced with Exhibit B2 attached hereto.

4. All other terms and conditions of the agreement dated October 8, 2019, between the County and Contractor shall remain in full force and effect.

*** SIGNATURE PAGE TO FOLLOW ***

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

COUNTY OF SAN MATEO

By:_____
President, Board of Supervisors
San Mateo County

Date:_____

ATTEST:

By: _____
Clerk of Said Board

TELECARE CORPORATION

Faith Richie
Faith Richie (May 5, 2020)
Contractor's Signature

Date: 05/05/20

EXHIBIT A2 – SERVICES
TELECARE CORPORATION
FULL SERVICE PARTNERSHIP
FY 2019 – 2021

In consideration of the payments set forth in Exhibit B2, Contractor shall provide the following services:

I. Description of Services to be Performed by Contractor

Contractor shall provide full service partnership "Full Service Partnership" or "FSP") mental health service programs for the highest risk adults ("Adults") and highest risk older adults ("Older Adults" or "OA") / medically fragile adults ("Medically Fragile" or "MF") in San Mateo County and housing services for these FSP enrollees. The purpose of these programs is to assist consumer/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures, and communities. Contractor shall work with San Mateo County Behavioral Health & Recovery Services (BHRS) staff ("County") to implement these services in accordance with requirements of the California Behavioral Health & Recovery Services Act (MHSA) requirements.

II. Full Service Partnership Scope of Service

A. Program Goals

1. Divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill (SMI) and complex individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support.

2. Offer "whatever it takes" to engage complex adults and older adults with SMI in a partnership to achieve their individual wellness and recovery goals, using alternative models of care which offer greater benefits to them, increasing the likelihood that they will experience positive outcomes.

3. Maximize use of community resources as opposed to costly crisis, emergency, and institutional care.

4. Use strategies relating to housing, employment, education, recreation, peer support and self-help that will engender increased collaboration with those systems and sectors.

B. Target Population

The program will be open to adults and older adults meeting the population criteria described below. Special consideration is directed towards historically underserved populations including but not limited to Asian/Pacific Islander, Latino and African American populations. Both Medi-Cal and non Medi-Cal eligible consumers will be offered the opportunity to participate.

Most of the adults with SMI served by the FSP will have histories of hospitalization, institutionalization, substance use, not engaged in medication treatment, and difficulty in participating in structured activities and living independently. Some individuals may have histories of assaultive behavior. It is possible that many consumers will have resided in long term care facilities for extended periods. For some of these individuals, patterns of service have relied almost exclusively on emergency and institutional care. Others have bounced in and out of every type of service without improved outcomes.

Older adults with SMI will likely have cognitive difficulties and medical co-morbidities. Some SMI adults and older adults will be medically fragile. This group of consumers may have resided in long term care facilities for extended periods or be at risk of placement. The program will serve as a step-down program for acute care, locked placements, and skilled nursing facilities in order to avoid prolonged institutional placements that often hasten the loss of an individual's sense of wellness, independence, and overall quality of life.

Populations to be served by the program are:

1. Individuals whose SMI and the complex nature of their diagnoses and medical or other concerns result in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement.

2. Adults with SMI, and possibly substance use issues and current incarceration, and for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization.

3. Adults with SMI, often co-occurring substance use, currently placed in locked MH facilities; the FSP will target individuals living in sub-acute locked facilities located outside the county as a step-down, enabling them to return to their community. Many of these individuals will have behavioral problems that have caused them to be viewed as "difficult" IMD residents.

4. Older adults with SMI who are medically fragile and may have additional complex issues including: dementia; are at risk of institutionalization or currently institutionalized; and who, with more intensive supports, could live in a community setting.

C. Values and Principle

1. Service Values

a. Community-based services are those that foster the greatest independence in the least restrictive, most accessible, familiar setting. Community-based services are also those which are offered to consumers where they live, work, or recreate.

b. Consumer participation is voluntary. This does not preclude intensive outreach to potential consumers.

c. Services are to be recovery based and guided by an individualized plan developed between consumer and staff and signed off by the consumer. Staff will employ a variety of supportive and recovery techniques to encourage consumers to assume responsibility for their own wellness and recovery.

d. Services will integrate client's family members or other supportive people into treatment whenever possible via consumer consent. Consumers will be given ongoing opportunities to choose what family members or other supportive people, if any, they would like to be involved.

e. Advisory Board: Consumers will be encouraged to have an active role in making decisions about program operations through an advisory board or similar structure. Substantive changes in program structure and service operations will be communicated back to consumers via the governing board or other communication method.

f. Lived Experience: Consumers are actively recruited for staff positions so as to incorporate the consumer perspective throughout the agency. Although Contractor currently has a number of staff with lived experience, efforts will be made to develop specific positions for persons with lived experience.

g. Consumers are provided self-help and peer support opportunities.

2. Operational principles and practices

This program is grounded in research and evaluation findings of California's Mentally Ill Criminally Ill Crime Reduction (MIOCR) program and national effectiveness research through the federal GAINS/TAPA Center. These demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors.

Research has also demonstrated that the models using team-based services have been effective in reducing hospitalization and costs. The following are key elements of that model:

a. High staffing ratio of staff to consumers; research shows that programs are most effective with a ratio of one to ten or fewer.

b. Team staff all work with and share responsibility for each consumer.

c. There are frequent team meetings to discuss all team consumers.

d. There is contact each week between staff and each consumer.

e. A psychiatrist is assigned to each team and participates in team discussions and decisions as well as prescribing medication.

f. A licensed professional who can administer medications in the field is assigned (at least part time) to each team in the field.

g. There is full continuity of care including medication access at any time, and staff involvement with all stages of hospitalization.

h. Comprehensive, culturally competent assessment of each enrolled client's service needs and objectives, including, but not limited to, needs for MH services, rehabilitation, housing, employment, education, social and recreational activities, and health care.

i. Development and implementation of a Plan of Care for each enrolled client, which incorporates the treatment goals and objectives in accordance with principles outlined in the Short-Doyle/Medi-Cal Manual and serves as the authorization document for all services.

j. Case management or treatment teams organized to respond to fluctuations in service intensity and able to assure integration of services and continuity of care.

k. Treatment of psychiatric conditions in appropriate settings, including but not limited to emergency care, acute inpatient services, long term care, residential treatment and residential care.

l. Medication treatment as appropriate and medication management.

In general, these programs have successfully improved rehabilitation outcomes by using their own staff specialists who are closely integrated into the team. However, successful rehabilitation programs have been demonstrated using other models. Regardless of the model, the following recovery-based program elements should be available via direct provision, purchase of service, interagency agreements, or other means.

m. Consumer self-help and peer support services.

n. A program for assisting consumers to become involved in paid work and/or education. This includes direct services or referral to vocational assessment, job development, supported employment, competitive employment, and other employment services.

o. Money management, including serving as representative payee where appropriate, income maintenance services and assisting consumers with budgeting.

p. A program for assisting consumers to develop social, recreational and relationship skills.

q. Substance use treatment programming; preferably integrated with team or case management services.

r. A program that will be used to support consumers in independent housing choices.

s. Transportation as needed to implement each consumer's Plan of Care.

t. Consumer education programs.

u. Provide FSP orientation, information and other services to family members to support consumers' recovery.

v. Twenty-four (24) hour, seven (7) day a week crisis response capability, including in-home support services and services at other consumer locations as appropriate.

w. Plan for linkage to and coordination with primary care services, with the intent of strengthening the consumer's ability to access healthcare services and ensuring follow up with detailed care plans.

3. Culturally Competent Elements

The ethnic/linguistic populations that are emphasized for FSP enrollment are those that have experienced the greatest disparities in access and services utilization in San Mateo County's mental health services system. Services should be linguistically and culturally competent and provided to a substantial degree by staff from the same ethnic/linguistic groups as consumers. To successfully address the targeted populations the program must incorporate culturally competent elements:

a. A culturally competent service provider or system acknowledges diversity and recognizes its value, is knowledgeable about cultural differences and can provide high quality services adapted to meet unique cultural needs.

b. Culturally competent services are designed to reach and engage diverse communities and are sensitive to the consumer's cultural identity, use culturally appropriate strategies, are available in the client's primary language and use the natural supports provided by the consumer's culture and community.

c. Goal setting and planning processes are culturally sensitive, individualized and build on an individual's cultural community resources and context. Services plans reflect and respect the alternative therapies or healing traditions and healers of each individual consumer.

d. Services design will respect and engage each individual's family, community and other support systems contingent on his/her wishes.

e. Staff will consider consumers spirituality during assessment and treatment. Staff should have the skills to understand the spiritual interests, beliefs and worldviews of consumers and families in order to integrate these into treatment goals whenever appropriate.

f. Contractor shall develop and provide to BHRS policies for hiring consumer staff who have their own experiences in facing the challenges of mental illness and/or alcohol and other drug addiction. These policies should indicate how the Contractor will recruit individuals with these skill sets or life experiences.

g. Contractor shall develop and provide to BHRS policies for hiring individuals who self-identify as LGBTQ, or who are very experienced and comfortable working with consumers who self-identify as LGBTQ, in the delivery of services.

D. FSP and Criminal Justice Realignment Services

1. FSP services are delivered by multidisciplinary teams; this is not a brokering model. Staff will be available to consumers 24/7 and service plans will be designed to utilize community relationships that are already well developed and in place. The inclusion of a behavioral health nurse on the team along with dedicated psychiatric staff will allow consistent medication evaluation and rapid linkage to physical health providers. Within each team, a personal services coordinator is identified for each enrolled consumer. There is a 1:10 staff to consumer ratio for the intensive level of services.

2. The FSP team will operate under policies and procedures that ensure:

a. 24-hour, 7-day a week availability of program staff, including access to medication support services. Night and weekend treatment and support or wellness and recovery activities should be assumed as a part of program services. Consumers will have access to an emergency number to call during off hours where their situation can be assessed and responded to 24/7, including face-to-face visits.

b. Interventions with consumers are mostly face to face visits. Contact with each client will occur as often as clinically needed, which may be daily.

c. Consumer treatment will include a variety of modalities based on consumer need including, but not limited to, case management, individual or group therapy, psychiatric medication prescription, and general medication support and monitoring.

3. Continuity of care will be emphasized and will include:

a. Engagement during inpatient episodes includes face to face visits when allowed by the facility with the consumer at local hospitals and other locked facilities. For San Mateo Medical Center PES and 3AB (the SMMC in-patient psychiatric unit), FSP program staff will make phone contact with the medical facility within 4 hours of knowledge of client arrival and make an initial visit with the client within 24 hours of client entry.

b. Regular contact will occur with the consumer and with inpatient treatment staff while the client is hospitalized. During these episodes, the FSP will work with inpatient staff to make discharge recommendations and facilitate the client's return to the community.

c. Engagement during criminal justice contacts. FSP program staff will be quickly responsive to and maintain contact with criminal justice clinical Navigators at Maguire jail when a consumer becomes incarcerated. Program staff will visit consumers when possible and work with criminal justice clinical Navigators to devise and implement a discharge plan.

d. Coordination including but not limited to the consumer's medical provider and assistance in following through on detailed care plans which includes transportation to and from related appointments.

4. FSP teams have final accountability for assuring the delivery of services and are responsible for service outcomes. FSP staff will generally deliver the services identified in the individualized plan, and most consumers will not be served by other parts of the behavioral health service delivery system unless stepping-down to a lower level of services. However, in some instances it may work best for a consumer to continue some services in another part of the behavioral health system (e.g., employment services). The FSP team will work in collaboration with the other service providers to assure implementation of the individualized plan.

5. FSP services will be supported by existing BHRS relationships with all aspects of the criminal justice community including Probation, Parole, Sheriff's Department and municipal Police Departments.

   a. FSP staff will collaborate within the Community Service Area (CSA) where individual consumers reside and participate in current and future collaborative meetings which address consumers at risk in the community, communication barriers between treatment providers or within the CSA, collaborative structures and approaches to make treatment more accessible and residential placement or incarceration less likely.

   b. FSP program staff will also participate in twice monthly case conference meetings with BHRS and an annual review panel to assist in the management of the consumer level of care needs.

   c. The FSP staff and the BHRS Criminal Justice navigator staff and Service Connect staff will build a collaborative relationship to coordinate and communicate with one another regarding consumers, and in particular, transition planning for consumers being released from jail.

   d. FSP program staff will also communicate substantive changes in a consumer's, health, behavioral health, or criminal justice status immediately to BHRS, and/or the Conservator's office and will collaborate to assist the consumer to resolve those issues.

6. FSP staff will have access to flexible funds so that resources can be provided that assist the consumer in achieving recovery plans.

7. Medication services will include psychiatry and nursing support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. FSP team members will work with individual consumers to arrange for delivery/prompts/reminders that will support regular scheduled medications.

8. Should psychiatric inpatient care be necessary and appropriate, it will be provided as it is now, through current processes.

9. The FSP teams will provide co-occurring mental health and drug and alcohol services and supports such as individual and/or group therapy, Motivational Interviewing and harm reduction approaches. FSP programs are strongly encouraged to become certified as a Drug Medi-Cal provider. Staff will be trained in co-occurring treatment modalities and will develop commensurate programming, including groups. Drug/alcohol use will not be used as a reason for program termination.

10. At intake, a housing stability assessment will be conducted with the consumer to assess the extent to which housing subsidies, or the level of housing supports, are needed to sustain the consumer in housing. However, it is recognized that it will be important to provide temporary housing for some consumers as rapidly as possible, to avert incarceration or to shorten or prevent a sub-acute inpatient stay.

    a. The goal is to provide permanent independent housing throughout the community.

    b. Significant housing resources will be available to consumers in this program in the form of rental subsidies for adults and older adults.

    c. The FSP housing resources for all age groups will include a variety of levels of housing including independent, Board and Care, and supported housing.

11. The FSP will foster and promote the values of recovery/resiliency through its emphasis upon a strength-based approach to services and individual service planning. Service plans will be used to help consumers identify, cultivate and sustain relationships with peers, family members, neighbors, landlords, employers, and others to create a network of support that will build the resiliency of consumers.

12. While services provided through this initiative will address the individual's underlying mental health, substance use and behavioral problems that may have contributed to involvement in the criminal justice system and institutionalization, a wide range of strategies and supports beyond behavioral health services will be essential. Substantial time and resources will be devoted to the process of engaging individuals, including outreach to those in institutions and locked settings. Services will be provided in the field, in natural settings where people conduct their lives as opposed to a clinic setting. Staff members of this program will be creative in their approach to identifying what approach or resource will make a difference to a particular individual in engaging them in treatment.

13. The Peer Partner will play a critical role, modeling personal recovery, helping consumers establish a network of peer, family, and cultural supports. One of the primary roles to be performed by the FSP team Peer Partners will be to establish peer relationships among FSP consumers and promote peer involvement in wellness and recovery, social, recreation, and entertainment activities. Peer support groups will be developed to further foster healthy peer relationships and to build consumer capacity to address challenges to their recovery as well as celebrate their accomplishments on the journey to recovery. This peer and resource linkage will also help maintain the client in the least restrictive environment.

14. Consumers will work with FSP team members to develop their own individual service and Wellness and Recovery Action Plans (WRAP) which will specify individual action steps in relation to employment, education, housing, medication, peer relations, social activities, and education. All services will be voluntary, guided by individual choice, and the delivery of all services will be guided by the principles of cultural competence, recovery and resiliency with an emphasis on building consumer strengths and natural resources in the community, with family, and with their peer/social network. The program will be designed to allow a greater or lesser degree of support and structure, depending on the needs and goals of the consumer at any given time.

15. FSP program will assess the vocational needs for each consumer upon enrollment and annually and assist consumers in accessing vocational counseling services to identify, obtain, and retain employment opportunities and reach their vocational goals as identified in their care plan.

16. Supported education is another resource for FSP consumers. The FSP team should link with community colleges and the existing contractor for adult supported education services in San Mateo County, developing action steps in the recovery plan related to educational opportunities for consumers.

17. Consistent with the principles of wellness and recovery, the consumer will be primarily responsible for establishing the specific goals that define his/her desired quality of life including healthcare and end of life decisions. The licensed clinicians will oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family contingent on the consumer's wishes. This plan will define the roles and responsibilities of the team, as well as those of the consumer, the family, and peers.

18. The role of the nurse will be to enable the team to more effectively collaborate with primary care providers, assist consumers in both their communications with their primary care doctors and in their follow-up on medical care, including medical treatment regimes, and lifestyle changes due to medical complications and provide adherence to treatment protocols. The role of the nurse in providing education and monitoring of and adherence to medical treatment will increase medical and medication engagement and enable the consumer to maintain their community placement.

19. The FSP program staff will assess and arrange for services and supports as appropriate for each client based on a range of supports including:

    a. Transportation and escorted services to assist at medical appointments and with other transportation needs.

    b. Monitoring and/or arranging for home-based support with routine tasks and personal care needs (e.g. meal preparation, house cleaning, laundry, shopping, bathing and other hygiene needs), and coordinating with involved agencies such as In-Home Supportive Services.

    c. Providing social supports and facilitating access to supports to address isolation and loneliness.

20. The FSP program will collaborate when necessary with the Human Services Agency, the Health Department (Aging and Adult Services), San Mateo Medical Center (Primary Care) and a variety of contract agencies that provide board and care, acute care and other supportive services. The FSP will engage and empower natural community supports that will extend the impact of the FSP staff.

E. Admission, Discharge and Length of Stay

1. Contractor will comply with the "AIRS" policy, process and procedures for intake into FSP services. This includes informing BHRS Adult Resource Management when a non-BHS consumer is interested in accessing services or residing in a residential or supported housing facility.

2. The BHRS FSP Review Committee oversees the referral and authorization process and the process of consumers transitioning to a different level of care in collaboration with the FSP provider.

3. For the CJR population, the BHRS Criminal Justice Team will assess needs and will refer directly to the CJR FSP program.

4. Disagreements regarding referrals will ultimately be resolved by BHRS Deputy Director of Adult and Older Adult Services or designee and Contractor's Administrator.

5. The FSP and CJR will admit individuals referred to their respective FSP programs by BHRS. Consumers will be referred for FSP services based on acuity and need for intensive level services based on the following:

   a. FSP Criteria:
      LOCUS level 4 or higher AND at least one of the following:
      i. Three PES/ED visits in last 60 days; AND/OR
      ii. Two inpatient psychiatric hospitalizations in last 6 months with most recent hospitalization in past 30 days; AND/OR
      iii. Transitioning out of a locked/secure facility (i.e. MHRC, Secured SNF, Jail, or Out of County Placement); AND/OR
      iv. Loss of current support system that would potentially result in hospitalization, incarceration or other form of locked placement without FSP level services based on past history.

   b. CJR FSP Criteria and Enrollment Process
      Consumers referred are directly referred from the Criminal Justice Department to the BHRS AB109 program for follow-up care and integration into the community. Consumers are referred based upon the following criteria:
      i. Client meets any/all of the FSP criteria as referenced in section II.E.5.i-iv.
      ii. The BRHS PRT will assess and identify consumers for enrollment and determine appropriate level of care. Factors for consideration shall be the AB109 team assessment, client's length of incarceration time, client's support system, and client's functioning level.
      iii. There will be an initial case discussion about the proposed referral to the CJR FSP. This discussion will include a review of documentation and the assessment completed by the BHRS PRT team.
      iv. After the case discussion, Telecare will notify BHRS PRT of the client's acceptance within 48 hours.
      v. Enrollment will occur immediately after acceptance.
      vi. The FSP PRT will collaborate on initial treatment planning for each client and engagement strategies.

6. The FSP Review Committee will be convened as needed to ensure FSP slots are filled when they become available.

7. Transition planning begins at assessment, with step down planning as a part of the overall service plan. The FSP Review Committee will conduct an annual review to discuss client level of care needs and potential transition plans to another level of care within the FSP program or discharge out of the FSP program. Cases will also be discussed regarding client level of care needs within each month at the partnering meetings between BHRS and the FSP program.

8. Indicators related to transition include but are not limited to stable housing, no PES or inpatient utilization, no incarceration or arrests, participation in meaningful activities, symptom management, and overall improved quality of life.

9. If a consumer enrolled in a FSP is consistently unsuccessful in the program or requires short term or long-term placement (after other alternatives have been fully explored) the FSP program may present this case for consultation at the BHRS/Telecare case management meeting to determine how best to proceed. If short term placement is agreed upon and authorized, the FSP will maintain contact with the consumer and plan for return to the FSP program.

10. The FSP will also present to the case management meeting cases in which consumers choose to dis-enroll from the program or are otherwise no longer appropriate for FSP level of care. Every opportunity will be given in advance for the client to be re-engaged before disenrollment, during which time the program will be responsible for continued outreach/engagement as well as linking the client to alternative services.

11. Length of stay in the FSP program is determined by client level of care needs which will be assessed regularly by the FSP provider and formally discussed on an annual basis at the case management meeting. FSP providers will develop and implement an internal system of review of consumer level of care needs to assess when consumers may be ready to graduate from FSP services.

12. Housing subsidies for FSP consumers may be managed as part of a separate contract for management of housing subsidy resources.

13. A collaborative active utilization review process will be maintained at a minimum of monthly meetings. This process will ensure that consumers are seen at an appropriate level of service that matches their service needs and LOCUS level.

14. A list of consumers that are maintained in a locked setting (including SMMC, 3AB or other psychiatric facility, jail and/or prison) for more than 60 days will be submitted to BHRS on a monthly basis. In addition, Contractor will provide on a monthly basis a list of consumers that have had no contact with the FSP program (for any reason) for more than 45 days.

F. Staffing

1. See the Budget and FTE summaries that follow for a summary of the staffing assumptions that went into the MHSA Plan and budget.

2. Staff should reflect the ethnic/cultural/linguistically diverse populations that are identified in *2. Population to be Served.*

3. Desirable staff skills include CBT, motivational interviewing, and experience working with trauma, personality disorders, co-occurring disorders, and co-morbid medical conditions.

4. The Peer Partners must have personal knowledge and experience as a recovering user of behavioral health services.

Peers:	Have been or are currently served in the Behavioral Health (BH) system—peers are a source of support in both informal and formal locations in the BH system.
Peer Partners are:	Peers as defined above that are employed by the BH system to provide support to consumers, peer counseling, benefits counseling, assistance navigating the system and co-lead groups
Parent/Caregiver Partners are:	Parents that have had services from the behavioral health system for their families—they are peers to other parents of adults now receiving services and formally employed by the behavioral health system to focus on engagement, education and support for family members.

5. A quarterly updated staff roster and phone list will be provided to BHRS and to SMMC PES and 3AB.

G. Training

1. There will be system wide training for staff in county and contract programs that includes cultural competence, sexual orientation and gender differences, and consumer culture. Budget and staffing assumptions should align with County identified FSP needs as well as projected number of consumers.

2. Another component of training will be training for all county and contract staff in co-occurring disorder assessment and treatment skills.

3. County and contract staff will be trained in cognitive behavioral approaches, such as Trauma Focused CBT.

H. Funding

Full Service Partnership Funds, are funds to provide "whatever it takes" for enrolled populations.

1. The two hundred seven (207) slots will be funded with MHSA FSP funds.

2. The FSP budget includes funding for transportation and for flex funds.

3. Housing subsidies will be funded with MHSA FSP funds and managed through a separate contract. San Mateo County will work with the housing contractor and the FSP contractors to establish a small portion of the housing funds to be allocated to the FSP as flex funds specific to managing housing crises.

4. It is expected that all consumers will be assessed for insurance status and potential eligibility for third party coverage, and that assistance in obtaining coverage will be provided by the FSP team.

5. Provider is required to submit all necessary documentation in order for Medi-Cal and Medicare reimbursement.

6. There will be a two-year contract period.

    a. Contracts will be based on units and unit costs, with a cost settlement. Unit costs must not exceed the State Short-Doyle/Medi-Cal Maximum Reimbursement rates.

b. The method of payment for FSP services will be fee for service. The method for reconciling Medicare and other 3rd party payments recouped by the contractor will be negotiated.

7. See the Budget and FTE summaries that follow for a summary of the financing assumptions that went into the MHSA Plan and budget.

J. Quality and Outcomes

1. A specific component of the San Mateo County Quality Plan will be developed to track FSP programs.

2. The key outcomes include:

   a. Residential / Hospital / Incarceration Status;

   b. Justice System Involvement Status;

   c. Emergency Intervention;

   d. Education;

   e. Employment;

   f. Benefits;

   g. Conservatorship / Payee Status.

3. These domains, as well as the method of data collection, Key Event Tracking (KET) and Quarterly Assessment Form (3M), are consistent with the measurement strategy developed by the AB2034 program - which has been successful in demonstrating that program's effectiveness. It is crucial that the vendor maintain accurate, timely reporting of outcome data.

4. The indicators/domains to be collected by the KET method are *those which are best measured as the changes are occurring.* These would be domains such as residential status. Residential status is a domain for which all changes are relevant. For example, it is important to know when and to what type of residence a person moved, in order to count the days in different types of residences, as well as the progression toward more independent living over time. If residential status is only collected on an interim basis, e.g., annually, the resulting data are not very meaningful, nor useful.

5. Other indicators/domains will be measured using the 3M tool. This measure will produce quarterly summaries of the consumer's progress in important areas such as, education, financial support, legal status and issues, health status, substance use, and activities of daily living.

6. The FSP contractor will be required to provide, via San Mateo County, Client and Service Information (CSI) to meet State DMH requirements.

K. Service Model

1. Contractor shall provide whatever might be necessary to perform the following:

   a. Twenty-four (24) hours per day, seven (7) days per week availability of program staff services including:
      i. medication and medication support services.
      ii. continuity of care during inpatient episodes including visits with local hospitals and locked facilities that allow program staff to have regular contact with the enrollee and with inpatient treatment staff while the consumer is hospitalized.
      iii. continuity of care during criminal justice contacts.
      iv. coordinate with enrollee's primary care physician and assist enrollee in following through on detailed care plans.
      v. contact each enrollee as often as clinically necessary, which might be daily. Minimum contact is two (2) times per week for intensive service level.

   b. Average service time per enrollee

Contractor will provide an average service time of four and one half (4.5) hours per week per enrollee. Each week enrollee will be seen no less than two face-to-face meetings. This average service time refers in the intensive (1-10) level of treatment.

c. Crisis Response

Contractor will develop and or maintain policy and protocol that includes the following:

i. Staff will assist consumers to complete a safety plan within 30 days of intake. This plan will be reviewed minimally on an annual basis or more frequently as needed with the consumer and will include the following elements:
   (1) Signs and symptoms of distress or decline in mental health status;
   (2) Emergency numbers to call;
   (3) Family members and/or other consumer supporters, including contact information and a signed written release of information form detailing what information may be shared;
   (4) Historically effective coping strategies and healthy ways to relieve stress in non-emergency situations.

ii. Identified family members and loved ones of the consumer will be given information with consumer consent, upon consumer's intake into the program and annually, about effective ways to respond to the consumer if/when consumer is experiencing a psychiatric crisis. The program staff will encourage family members and/or other identified consumer supports to inform staff when noticing signs of decompensation. Family members and/or other identified consumer supporters will be given a script to use with police or other emergency personnel when encountering their family member in crisis. They will also be given suggestions regarding what resources to call in different types of situations. Those resources may include:
   (1) The FSP provider and team emergency or regular contact lines;
   (2) Toll free crisis line;
   (3) 911 and local police department with the potential aide of CIT trained police officers and/or the SMART team.

d. Off-hour crisis response system
   i. Contractor will provide face to face contact 24/7 as required by enrollee need.

e. Medication/Medication Support
   i. Contractor will provide necessary and required individualized medication services in a collaborative manner with enrollees.
   ii. Physician and licensed nursing staff will meet in vivo as indicated with enrollees to ensure appropriate education and medications as aligned with culture and lifestyle.
   iii. FSP teams work with individual enrollees to arrange for delivery and prompts that supports enrollees taking medications as prescribed.
   iv. Medication assessment and management shall consist of at least one (1) face-to-face visit conducted by a licensed physician (psychiatrist).
   v. Dispensing medication, or assisting consumers to dispense their own medication, shall be done by either a licensed physician (psychiatrist) or a licensed/registered nurse.
   vi. Medication support performed by staff consists of observing consumers taking their medications, and encouraging communication with their psychiatrist regarding any non-urgent side effects or medication concerns.

f. Consumer and Family Participation
   i. A consumer council and a family support group will provide a formal mechanism for enrollees/families to provide input into program management and direction.
   ii. Contractor will employ at least three (3.0) FTE consumer/family member.
   iii. Contractor will utilize paid consumer consultants to participate in the provision of wellness and recovery action plans ("Wellness and Recovery Action Plans" or "WRAP") services.
   iv. Contractor will utilize after hours call-in phone service to respond to urgent client calls. Consumers will receive a risk and needs assessment and will be responded to appropriately.

v. Contractor will utilize peers to provide medication support, assistance with activities of daily living, transportation and accompaniment to service plan related appointments, conflict resolution with housemates, assistance with access to benefits, and crisis prevention.

vi. Contractor will develop a written policy and implement a process whereby staff (who identify as persons with lived experience), or family partner will assist with orientation of new consumers, assist new consumers in the development of a support system, and help family members understand the FSP program and services available. Written orientation materials will be provided that include information on HIPAA, the National Alliance for the Mentally Ill (NAMI), and the BHRS Office of Consumer and Family Affairs.

vii. The family partner shall assist caregivers in facilitation and active engagement of the Family Team goals by:
   (1) supporting caregivers in identifying, creating and working with resources to sustain tasks and goals set by the consumer, caregivers and treatment team;
   (2) working in cooperation with the consumer, caregivers, and treatment team;
   (3) participating in family team meetings and treatment meetings.

viii. The family/caregiver support group shall provide a venue for caregivers to gather and share their experiences and to:
   (1) Increase knowledge of mental illness, symptoms, causes, treatments and management;
   (2) Increase knowledge of practical management skills;
   (3) Increase family/caregiver communication skills;
   (4) Provide opportunities for family/caregivers to expand support networks.

g. Illness Management/Medical Treatment Support

i. Contractor will ensure enrollee physical and dental health needs are identified. Contractor's staff will collaborate with primary care providers and assist enrollees in both their communications with their primary care providers and in their follow-up on medical care, including medical treatment regimes, and lifestyle changes necessitated because of medical conditions. The role of the team nurse is to ensure the provision of education and monitoring of medications which will increase medication engagement and enable the enrollee to maintain their community placement.

ii. Contractor will develop and maintain relationships with other health care providers to facilitate enrollee being maintained in community.

h. Housing and Housing Supports

Contractor will provide continual support to enrollees to ensure success in attaining and maintaining housing based on client need and availability of standard resources.

BHRS PRT will assist with coordination with County Human Services Agency housing resources as appropriate for consumers enrolled in the CJR FSP program.

i. Evidence Based and Promising Practices

Contractor will provide clinical staff with training and skills in the following areas:

i. Wellness management and recovery
ii. Cognitive Behavioral Therapy
iii. Motivational Interviewing
iv. Life skills training
v. Dual Diagnosis (Mental Health/Substance Abuse)
vi. Harm Reduction
vii. WRAP Plans

j. Benefits

i. Contractor will ensure all enrollees are assisted in maximizing financial/health benefits.

ii. Contractor will make best efforts to ensure enrollees develop independent banking and fiscal responsibilities.

iii. Contractor will work towards providing representative payee services to all enrollees who require such assistance.

k. Vocational & Educational Services

Contractor will provide services necessary to identify and attain employment and educational opportunities.

l. Individualized Service Plans
   i. Contractor will ensure that all plans are completed in collaboration with enrollees and are consistent with enrollees stated goals.
   ii. Contractor will facilitate all enrollees developing Wellness and Recovery Action Plans.

m. Specific to Older Medically Fragile Adults
   i. Contractor will work with enrollees to maximize social and daily living skills and assist in formalizing contacts with community programs and agencies.
   ii. Contractor will facilitate the use of in-home supportive services i.e., health aides and home care nursing agencies.
   iii. Contractor will develop and maintain relationships with other health care providers specific to this population (i.e., Ron Robinson Senior Care Center).

n. Flexible Funds

Contractor will ensure a system to access flexible funds easily allowing resources to be used to assist enrollee in achieving rehabilitation goals and to maintain stability. Policies are to be developed to ensure accountability of funds. Where possible funds are to be treated as loans that will be repaid by enrollees.

o. Representative Payee Services

Contractor will provide representative payee services for those consumers that require fiscal management in order to meet their day-to-day needs and remain stable in their current living situation. Services will include, but not be limited to, the following guidelines:

i. All income and benefits must come from government sources such as Social Security (SSI), Railroad Pensions, and Medi-Cal/Medicare.
ii. The need for money management services shall be demonstrated through documented examples of skill deficits that prevent successful self-management of funds.
iii. Consumers, who are competitively employed, own and maintain cars and/or own and maintain homes may not be candidates for Representative Payee services.
iv. Contractor will establish and utilize the following documents: a "Representative Payee Agreement", a "Representative Payee Consent Form", and an initial and ongoing budget plan or spreadsheet.
v. Separate records will be maintained for each client receiving payee services. Contractor shall keep all records for at least 2 years.
vi. A surety bond will be obtained to cover the funds managed.
vii. Contractor will observe state guidelines for representative payees. Guidelines are available at: http://www.socialsecurity.gov/payee.
viii. Contractor will develop an agreement template for payee services that informs the consumer of the duties the Contractor shall perform on the consumer's behalf and any obligations the consumer may have.
ix. Contractor shall pay rent and utilities (or Room and Board) and other bills directly to the service provider.
x. Contractor shall not charge consumers a fee for representative payee services.

L. Projected Capacity

Service Level		Year 1	Year 2
Intensive		167	167
Case Management		30	30
Wellness & Recovery		10	10
Total		207	207

M. Telecare Staffing

Outpatient and Admin Staff		Year 1	Year 2
Program Administrator		1.2	1.2
Clinical Director		1.0	1.0
Nurse Practitioner		1.0	1.0
Rehab. Specialists/PCS II		11.0	11.0
Vocational Specialists		1.0	1.0
Team Leader		3.0	3.0
RN Supervisor		1.0	1.0
LVN/LPT		1.4	1.4
PSC/RAL/Counselor		3.5	3.5
Receptionist		1.0	1.0
Driver		1.0	1.0
BOM/Program Specialist		1.0	1.0
Med Records Tech		1.0	1.0
Admin Assistant/HR		1.0	1.0
Financial Services Tech		1.0	1.0
Total Outpatient & Admin Staff		30.1	30.1

Housing Staff		Year 1	Year 2
Housing Manager		1.0	1.0
Supportive Housing Specialist		4.2	4.2
Total Housing		5.2	5.2

Dormitory Staff		Year 1	Year 2
Housing Manager		1.0	1.0
Supportive Housing Specialist		4.2	4.2
Total Dormitory		5.2	5.2

SSF Housing Staff		Year 1	Year 2
PSC II		0.5	0.5
Total SSF Housing		0.5	0.5

		Year 1	Year 2
Total All FTEs		41.0	41.0

N. Volume of Services:

Contractor will provide the minimum volumes of services per contract period as established below. The services to be provided are defined in the San Mateo County BHRS Documentation Manual. The minimum number of eligible units are as follows:

Year 1 (FY 2019-20)
Minutes of Service 680,000

Year 2 (FY 2020-21)	
Minutes of service	680,000
Program Total	1,360,000

III. Criminal Justice (CJ) Realignment Full Service Partnership (FSP)

A. Target Population

Consumers served by the FSP may have serious mental illness and co-occurring disorders. Some consumers will have serious mental health conditions and will be referred primarily because of their behavioral and emotional instability. Many of these consumers will have primary diagnoses of personality disorder and/or substance use, and they will have histories of interpersonal conflict and behavioral problems. Some may have a history of psychiatric hospitalization. Most of these consumers are difficult to engage in treatment and may not have been successful in traditional Alcohol and Other Drug (AOD) or mental health treatment programs. Although the crime they committed that led to incarceration may not have been violent, some of these consumers have histories of violent episodes. BHRS Probation Realignment Team (PRT) will fully disclose any known history of violence or self-harm in the consumers referred to Telecare.

B. CJR FSP Disenrollment

1. The PRT will meet at least monthly with the FSP to track consumers and monitor care.

2. Discussions about levels of care, Intensive 1:10, Intensive Assessment and Evaluation, Community Case Management and Wellness, will occur in this meeting. Consumers can move to higher or lower levels of care.

3. The Manager of BHRS PRT will make final level of care decisions including time frames (up to 90 days) for the intensive assessment and stabilization slots.

4. Differences between Telecare and BHRS PRT will be referred to BHRS Deputy Director of Adult and Older Adult Services for mediation with the FSP Administrator.

5. Disenrollment can occur when enrollee:

a. is arrested, convicted and sent to jail for 60 days or more

b. has violated probation and sent to jail for 60 days or more

c. has no contact and CJR FSP is unable to locate for over 90 days

d. requires medical or psychiatric hospitalization for over 90 days.

e. when CJR funding source is eliminated and client may be assessed for appropriateness to be referred to the regular FSP.

C. Collaboration

Team members will work closely with the multi-disciplinary team (MDT) of County Probation, Human Service Agency, and Behavioral Health and Recovery Services. Communication with the MDT will happen on a regular and routine basis. Team members will meet with the MDT during the second half of the MDT meeting on an as needed basis. BHRS staff will be available for bi-lateral consultation, consumer updates and status reports and for case conferencing on an as needed basis.

D. Program Values and Principles

1. Service Values

a. Community-based services: From a consumer's point of view, community-based services are those that foster the greatest independence in the least restrictive, most accessible, familiar setting.

b. From a provider point of view, community-based services are those which are offered to enrollees where they live, work, or recreate.

c. Consumer directed services: Consumer participation is voluntary. This does not preclude intensive outreach to potential enrollees. The consumer's consent is also necessary to provide family and other supports with clinical information. However, all efforts are made to help enrollees use family and other supports in recovery efforts. Services can be provided even during prolonged engagement process and client will be viewed as FSP enrollee.

d. Services are to be recovery-based and guided by an individualized plan developed between consumer and staff and signed off by the consumer.

e. Consumer direction goes far beyond simply asking consumers what services they want. Staff can develop many ways of presenting opportunities to consumers so that they have more real choices. In short, consumer direction involves doing whatever is necessary for consumers to assume management of their illness and their lives.

f. Relationships are non-coercive to the extent possible.

g. Consumers have an active role in making decisions about program operations through an advisory board or similar structure.

h. Consumers are actively recruited for all staff positions so as to incorporate the consumer perspective throughout the agency.

i. Consumers are provided self-help and peer support opportunities.

2. Service Model

CJR FSP will use evidence-based and promising practices that are effective with this population such as (but not limited to) pro-social skills development, CBT for criminal thinking, life skills development, motivational interviewing and relapse prevention with a forensic population, moral reconation therapy, and other promising and evidence-based practices with a forensic population.

a. Twenty-four (24) hours per day, seven (7) days per week availability of program staff services
   i. Contractor will provide medication and medication support services.
   ii. Contractor will provide continuity of care during inpatient episodes including visits with local hospitals and locked facilities that allow program staff to have regular contact with the member and with inpatient treatment staff while the consumer is hospitalized.
   iii. Contractor will provide continuity of care during criminal justice contacts.
   iv. Contractor will coordinate with enrollee's primary care physician and assist enrollee in following through on detailed care plans.
   v. Contractor will contact each enrollee as often as clinically necessary, which might be daily. Minimum contact is two (2) times per week for intensive service level.

b. Average service time per enrollee

   Contractor will provide an average service time of four and one half (4.5) hours per week per enrollee. Each week enrollee will be seen no less than two face-to-face meetings. The average service time refers to enrollees in the intensive (1:10) level of treatment.

c. Off-hour Crisis response system
   i. Contractor will provide face to face contact 24/7 as required by enrollee need.

d. Flexible Funds

   Contractor will ensure a system to access flexible funds easily allowing resources to be used to assist enrollee in achieving rehabilitation goals and to maintain stability. Policies ensure accountability of funds. Where possible funds are to be treated as loans that will be repaid by enrollees.

e. Medication/Medication Support
   i. Contractor will provide necessary and required individualized medication services in a collaborative manner with enrollees.

ii. Physician and licensed nursing staff will meet in vivo as indicated with members to ensure appropriate education and medications as aligned with culture and lifestyle.

iii. FSP teams work with individual enrollees to arrange for delivery and prompts that supports enrollees taking medications as prescribed.

iv. Medication assessment and management shall consist of at least one (1) face-to-face visit conducted by a licensed physician (psychiatrist).

v. Dispensing medication, or assisting consumer to dispense their own medication, shall be done by either a licensed physician (psychiatrist) or a licensed/registered nurse.

vi. Medication support performed by staff consists of observing consumers taking their medications, and encouraging communication with their psychiatrist regarding any non-urgent side effects or medication concerns.

3. Recovery Based Elements

a. Comprehensive, culturally competent assessment of each enrolled consumer's service needs and objectives, including, but not limited to, needs for mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care.

b. Development and implementation of a plan of care ("Plan of Care") for each enrolled consumer, which incorporates the treatment goals and objectives in accordance with principles outlined in the Short-Doyle/Medi-Cal Manual and Medicare standards which serves as the authorization documents for all services.

c. Client self-help and peer support services.

d. A program for assisting enrollees to become involved in paid work and/or education. This includes vocational assessment, job development, supported employment, competitive employment, and other employment services.

e. Money management, including serving as representative payee where appropriate, income maintenance services and assisting consumer with budgeting.

f. A program for assisting enrollees to develop social, recreational and relationship skills.

4. Culturally Competent Service Elements

Team members will have an understanding of the incarcerated population's institutional experience in both prisons and jail settings and how these experiences contribute to recidivism. Team members will be familiar with obstacles to community re-entry faced by formerly incarcerated persons, along with the impact of incarceration on families and communities. Finally, team members will have a working knowledge of the legal system, including the roles of county Probation, the Sheriff's Department and the courts, and of how to effectively work with these systems.

a. A culturally competent service provider or system acknowledges diversity and recognizes its value, is knowledgeable about cultural differences and can provide high quality services adapted to meet unique cultural needs.

b. Outreach and engagement strategies are designed to reach diverse communities where the populations identified in Paragraph II. A., Target Population, can be identified and engaged in services.

c. Successful teams engage and empower enrollees with plans that are appropriate to their needs, maximize the benefits derived from use of culturally appropriate strategies and supports and thus reduce under-utilization of services that puts the enrollees at-risk of placement in more restrictive settings, including incarceration. Focusing on consumer-generated goals that are culturally relevant empowers enrollees to engage in services and maintain that engagement, extending the time the enrollee can live in a community setting.

d. Culturally competent services are sensitive to the client's cultural identity, available in the client's primary language and use the natural supports provided by the client's culture and community.

e. Goal setting and planning processes are culturally sensitive and build on an individual's cultural community resources and context. Individual, culturally focused community supports are identified and integrated into planning. Service plans reflect and respect the healing traditions and healers of each individual enrollee.

f. Culturally diverse and culturally informed staff incorporate culturally relevant strategies, including alternative therapies and the use of families and extended families to provide natural supports for enrollees. The use of these culturally relevant strategies also builds enrollee commitment to treatment and their individual service plans.

g. Services design will respect and engage each individual's family, extended family and community contingent on his/her wishes.

h. Team members are trained in culturally competent practices. Services are delivered by bilingual, culturally competent staff.

E. Projected Capacity

Service Level		Year 1	Year 2
Intensive		10*	10*
Case Management		6	6
Wellness & Recovery		6	6
Total		22	22

**Up to 4 will be used for assessment and evaluation*

F. Criminal Justice FSP Staffing

	FTEs
Rehab. Specialists/PSC II	1.0
LVN/LPT	0.6
Total All FTEs	1.6

IV. MHSA Funded Housing Support Program

A. Description of Services

Contractor shall provide clients; referred by BHRS and who are FSP enrollees; with clean, safe, and affordable housing which is maintained in a good state of repair. Housing shall be located in areas that are readily accessible to required services such as transportation, shopping, recreation and places of worship. Contractor understands that there is a scarcity of such housing and securing housing at any level shall be done collaboratively with the needs of all of those being served by the mental health community in mind.

Contractor shall ensure the individual has a housing component to their personal service plan, and that progress in skill acquisition and the individual's living experience is reviewed and discussed with the individual on a regular basis no less than four (4) times per year. It is expected that such reviews shall lead to a revision of the housing component of the individual's service plan. These reviews may take place in individual sessions or group sessions as is appropriate.

Contractor shall be responsible for providing enrollment with housing units of mixed types including augmented board and care, dormitory, congregate and supervised living, Single Room Occupancy (SRO), shelter and independent living. Each type of housing unit shall provide a specific set of community living experiences, shall be supervised at rates determined by the individual's needs, and shall be financially subsidized at predetermined rates appropriate to the individual's needs and abilities. The contractor is responsible for locating niche placements, negotiating rates, paying supplemental costs over and above the client's ability to pay, and ensuring that clients meet their financial obligations. The living experiences and housing goals could include the following:

1. Supplemented/Augmented Board and Care

   This housing experience shall focus on developing a permanent living arrangement for the medically frail/elderly individual or an enrollee who needs on site supervision. The purpose of the supervision is to ensure that the individual is provided with medication management, and to the degree needed, is provided with assistance in securing both medical as well as psychiatric management. The services could include reminding the individual of medical and psychiatric appointments, providing transportation or escort to appointments and general observation of the individual's condition to insure whenever possible interventions to treat problems that may arise occur as early as possible.

Supplemented/Augmented Board and Care services shall be above and beyond those of regular licensed board and care programs. The contractor shall be responsible to insure the Board and care provider has the necessary skills to provide these services and that they are maintained on a regular basis. These skills may be secured through attending appropriate classes offered in the community, by the Health System or by the contractor.

2. Illinois House

Illinois House, located at 2690 Illinois Street in East Palo Alto shall provide up to six (6) non-dedicated beds and focus on developing a permanent living arrangement for the individual or enrollee who needs on site supervision. The purpose of the supervision is to ensure that the individual is provided with medication management, and to the degree needed, is provided with assistance in securing both medical as well as psychiatric management. The services could include reminding the individual of medical and psychiatric appointments, providing transportation or escort to appointments and general observation of the individual's condition to insure whenever possible interventions to treat problems that may arise occur as early as possible.

Supplemented/Augmented Board and Care services shall be above and beyond those of regular licensed board and care programs. The contractor shall insure the necessary board and care skills needed to provide these services and that they are maintained on a regular basis. These skills may be secured through attending appropriate classes offered in the community, by the Health System or by the contractor.

3. Supervised Living

The supervised living program is at the Industrial Hotel located on Cypress Avenue in South San Francisco. (Other sites may be used for supervised living as well.) The Industrial Hotel program will master lease a contiguous block of single rooms with the hotel. Contractor will develop and maintain the following:

a. Bi-weekly community meeting where clients will address how to keep their personal rooms and community space clean and safe.

b. A system for encouraging or incentivizing client participation in chores or community building activities.

c. Monthly meetings with BHRS Deputy Director and/or contract monitor to discuss IV. a and b and any major client, community or maintenance issues.

4. Single Room Occupancy

Contractor shall provide a more permanent housing situation for those individuals who choose to live in more manageable living situations with modest supports. The contractor is responsible to ensure that the rent is paid in a timely manner and that the living unit is maintained in a safe, clean and secure manner. The contractor shall make monthly room inspections or more often as is required to maintain the room in a clean and safe order.

5. Shelter Services

Contractor shall provide temporary living situations while relocating individual and program staff to more appropriate housing. The contractor shall insure that these temporary living situations are safe and meet minimal housing standards. The contractor shall strive to limit the use of shelters to a minimum and whenever a shelter is use, the individual with the program staff either develop, or in process of utilizing a new housing plan as part of the overall service plan.

6. Other Housing

There are a variety of housing resources available through San Mateo County Behavioral Health and Recovery Services that may be both available and appropriate for FSP enrollees, and could include half-way houses, room and board, etc. This category of housing shall be considered a temporary or transitional placement while an individual develops additional community living skills. The contractor shall be the primary case manager and be responsible for finding permanent living for consumers upon program completion. Contractor will provide consultation to program staff to ensure enrollee's success in the program, and to include in the individual's service plan, specific housing goals. The contractor shall also ensure that any individual placed in this type of housing follow any specific rules that may exist about living at that center, and that a component of the individual's service plan outline these housing goals.

7. Alcohol and Other Drug (AOD) Treatment Residential Programs

This housing experience shall be limited to those individuals who require a residential alcohol or drug treatment program. This category of housing should be considered temporary for the purpose of achieving a drug or alcohol treatment goal.

Contractor will work with AOD providers to subsidize (spin-off) after care permanent housing.

8. South San Francisco Apartments

Contractor shall provide .5 FTE PSC II (FSP Coordinator) for the 636 El Camino housing project. The FSP Coordinator will be on site and will work with the Mid Pen Service Coordinator, property management, and other FSP case managers who work with other MHSA tenants at 636 El Camino. The FSP Coordinator will also provide case management to FSP tenants.

Telecare will oversee the FSP Coordinator duties that are described in the Memorandum of Understanding (MOU) established by mutual agreement with Mid-Peninsula Housing, BHRS, and Telecare. The MOU is incorporated by reference.

The major duties of the FSP Coordinator include:

a. Assist property managers with lease-up and occupancy of apartments.

b. Act as on-site coordinator of all MHSA apartments.

c. Act as service coordinator and liaison to other MHSA service providers.

Telecare will participate in BHRS MHSA Housing certification review committee.

9. Independent Apartment or House Living

This housing experience shall focus on providing permanent safe and affordable housing where the individual has maximum control of their environment. The contractor shall ensure the property is rented and maintained in good repair, and that rent and utility payments are made in a timely manner. The contractor shall inspect the independent units on a regular basis and ensure when necessary, that all repairs are made as soon as possible. When living problems are identified, the contractor will ensure the treating team is notified and that the team takes immediate action to address any concern. The mechanics of the identification, leasing, and ongoing maintenance of independent housing are described in Section III.A.7.

a. Property Management
   i. Contractor property management assists clients in locating and acquiring safe, affordable housing. They help clients negotiate rental agreements, mediate landlord-tenant issues and establish and maintain utilities. Contractor leases, subleases, and/or acts as a rental guarantor for apartments to clients, enabling clients to establish a positive rental history.
   ii. Contractor property management staff shall collect and pay consumers' rent. Staff shall work closely with the Housing Authority to acquire, manage and maintain all housing contracts. When appropriate, staff shall help consumer acquire and maintain Section 8 Housing and Shelter Plus vouchers, ensure basic household maintenance, rental unit inspections and when necessary, pursue a legal eviction.
   iii. Contractor shall provide and maintain property liability insurance on all units.

iv. Contractor property management staff shall work closely with contractor case managers and peer counselors to provide integrated support services with independent living skills training and access to community resources to enable clients to maintain and retain their housing.

b. Placement of Individuals into Housing Units

i. The type of housing will be determined by client's previous rental history and housing problems, history of violence, history of drug or alcohol abuse and a criminal justice report. The following criteria shall be considered in determining the type of placement in housing: individuals who are registered sex offenders, individuals with a history of the manufacture or sale of methamphetamine, alcohol and drug abuse, history of residential fire setting, or people with significant histories of random violence with no information about a mitigating intervention or treatment.

ii. Contractor shall hold personal meetings with the tenant (client) to complete the screening process. Contractor shall focus on assessing the likelihood that any tenant applicant will be able to meet the essential requirements of tenancy as expressed in the lease as follows:

1) To pay rent and any other charges in a timely manner.
2) To care for and avoid damaging the unit and common areas, use the facilities and equipment in a reasonable way, to not create health or safety hazards, and to report significant maintenance needs in a timely manner.
3) To respect the personal and property rights of others
4) To not engage in criminal activity that threatens the health and/or safety of other residents or staff
5) To comply with health and safety codes and necessary and reasonable rules and program guidelines.

10. Rental Procedures

The contractor will meet the following objectives relating to rent collection and general tenant relations:

a. Contractor will ensure that 24/7 staff coverage is available to respond to housing landlord for any type of housing emergency.

b. Contractor staff will be available during regular business hours to assist tenants with a broad range of issues related to housing stability.

c. Contractor will establish a clear and consistent method for tenants to pay rent, including standard practices for providing notice to tenants regarding late payment.

d. When appropriate, Contractor will establish 3rd party rent payment mechanism for tenants.

e. Contractor will develop and administer a client satisfaction survey that assesses tenant satisfaction with housing and property management services.

f. Should it be necessary to begin the eviction process, Contractor will proceed according to legal statute and requirements.

11. Eviction Prevention

Individuals who are deemed continuously disruptive will become the subject of a meeting to identify possible intervention to alleviate the problem. The participants in such meeting shall be the Property Manager as applicable, the Program Supervisor, the FSP Provider staff and when possible, the individual tenant. Efforts will be made to determine if the disruption is the result of symptoms of illness, or if the resident is under the influence of alcohol or drugs when the disruption occurs. Meeting participants will seek to determine if there is a cause that can be ameliorated, reduced or eliminated to avoid eviction and will develop a plan of action based on complete, accurate and factual documentation of the activity. In cases where the disruptive behavior is a coping mechanism for symptoms which are never completely eliminated, participants will seek to identify housing that reduces interaction with others, while maintaining the necessary supports to keep the individual successfully housed.

12. Unit Maintenance and Habitation

a. One hundred percent (100%) of the units will meet local building and health codes at the time of initial rent-up.

b. One hundred percent (100%) of the units will be monitored by the contractor for proper functioning of safety issues including smoke detectors, plumbing, gas, electricity and heating systems and any issues or concerns will be reported immediately to the owner or the owner's designee.

c. Any hazards or other unsafe or unhealthy conditions that are reported by tenant, landlord, or program personnel will be investigated by contractor within twenty-four (24) hours. Life/Safety issues (including, but not limited to heating, plumbing, and electrical systems) will be corrected within forty-eight (48) hours, or client will be relocated to temporary housing until hazard or unsafe condition is repaired non-emergency repairs will be corrected within fifteen (15) working days.

d. One hundred percent (100%) of consumers needing accessibility modifications will receive them prior to move-in.

e. After thirty (30) days of trying to resolve a unit habitability issue, if the suitable resolution has not occurred, Contractor will report such occurrence to BHRS Deputy Director for Adult and Older Adult Services.

f. Contractor will also observe and monitor the effect of the level of the consumer's instrumental activities of daily living (IADLs) upon their ability to maintain the cleanliness of their unit or to report any maintenance issues. Contractor staff will make regular inspections of consumer's units as part of tenancy, and will work with consumers to improve the challenges they have in maintaining their living environment.

V. Special Circumstances Housing Placement

A. The contractor will support a community placement for a client when it is in the best interest of the client, is at the lowest level of care in which the client can function, and the contractor has allocated and committed all of the FSP housing funds.

B. Prior to placement, the contractor will make the request to the BHRS Deputy Director of Adult Services, provide detail of the need, immediate and ongoing cost, and evidence that all FSP housing funds have been allocated and committed. BHRS will review the request and provide written approval of the placement. Client is not to be placed without approval of Deputy Director or designee.

VI. ADMINISTRATIVE REQUIREMENTS

A. Quality Management and Compliance

1. Quality Management Program and Quality Improvement Plan

Contractor must have a Quality Management Program and submit a Quality Improvement Plan to Behavioral Health and Recovery Services (BHRS) Quality Management (QM) annually by June 30. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) the Contractor will maintain an audit disallowance rate of less than five percent (5%), and 3) first appointment will be within fourteen (14) days of referral or request of service. BHRS QM will provide feedback if the submitted plan is missing critical components related to San Mateo County requirements. Additional feedback may be available if requested prior to the submission date.

2. Referring Individuals to Psychiatrist

Contractor will have written procedures for referring individuals to a psychiatrist or physician when necessary, if a psychiatrist is not available.

3. Medication Support Services

For Contractors that provide or store medications: Contractor will store and dispense medications in compliance with all pertinent state and federal standards. Policies and procedures must be in place for dispensing, administering and storing medications consistent with BHRS Policy 99-03, Medication Room Management and BHRS Policy 04-08 Medication Monitoring located at www.smchealth.org/bhrs-documents. In particular:

a. Medications are logged in, verified, counted and added to inventory sheets.

b. All medications obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

c. Medications intended for external use only are stored separately from medications intended for internal use; food and blood samples are stored in separate refrigerators.

d. All medications are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.

e. Medications are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.

f. Medications are disposed of after the expiration date and recorded.

g. Injectable multi-dose vials are dated and initialed when opened.

h. A medications log is maintained to ensure that expired, contaminated, deteriorated and abandoned medications are disposed in a manner consistent with state and federal laws.

i. "Stock" medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

4. Record Retention

Paragraph 14 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of ten (10) years, except the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until ten (10) years beyond the person's eighteenth (18th) birthday or b) for a period of ten (10) years beyond the date of discharge, whichever is later. This rule does not supersede professional standards. Contractor may maintain records for a longer period of time if required by other regulations or licenses.

5. Documentation of Services

Contractor shall provide all pertinent documentation required for state and federal reimbursement including but not limited to Consent Forms, assessments, treatment plans, and progress notes. Contractor agencies must submit, via fax to Quality Management at 650-525-1762, their version of these forms for approval before the forms are to be used. Special attention must be paid to documentation requirements for residential treatment facilities. Documentation shall be completed in compliance with the BHRS Policies & Documentation Manuals (as defined in Paragraph II. of this Exhibit). Contractor agencies are required to provide and maintain record of regular documentation training to staff providing direct services. Proof of trainings including attendance by staff may be requested at any time during the term of this Agreement.

System of Care (SOC) Mental Health Providers shall document in accordance with the BHRS Documentation Manual located online at: http://www.smchealth.org/sites/default/files/docs/BHRS/BHRSDocManual.pdf.

SOC contractor will utilize either documentation forms located on http://smchealth.org/SOCMHContractors or contractor's own forms that have been pre-approved.

6. Audits

Behavioral Health and Recovery Services QM will conduct regular chart audits of Contractors. Contractor is required to provide either the original or copies of charts, including all documentation upon request. The Department of Health Care Services and other regulatory agencies conduct regular audits of the clinical services provided by BHRS and Contractors requiring submission of charts as requested. Contractor is required to provide all necessary documentation for external audits and reviews within the stated timeline.

7. Client Rights and Satisfaction Surveys

a. Administering Satisfaction Surveys

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

b. Beneficiary/Patient's Rights

Contractor will comply with County policies and procedures relating to beneficiary/patient's rights and responsibilities as referenced in the Agreement.

c. Advance Directives

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

8. Beneficiary Brochure and Provider Lists

Contractor must provide Medi-Cal beneficiaries new to BHRS with a beneficiary brochure at the time of their first mental health service from the Contractor. Contractors are required to be aware of and make available to BHRS Medi-Cal clients all mandatory postings listed at this website http://www.smchealth.org/bhrs/providers/mandpost.

9. Licensing Reports

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

10. Compliance with HIPAA, Confidentiality Laws, and PHI Security

a. Contractor must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI), including electronic PHI that it creates, receives, maintains, uses or transmits, in compliance with 45 C.F.R and to prevent use or disclosure of PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards. Contractor is required to report any security incident or breach of confidential PHI to BHRS Quality Management within twenty–four (24) hours.

b. Contractor will develop and maintain a written Privacy and Security Program that includes administrative, technical and physical safeguards appropriate to the size and complexity

of the Contractor's operations and the nature and scope of its activities.

c. Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:

1) Acknowledge that in receiving, storing, processing, or otherwise using any information from BHRS about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;

2) Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and

3) Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

d. Confidentiality Training

Contractor is required to conduct, complete and maintain record of annual confidentiality training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

11. Site Certification

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

b. Contractor is required to inform BHRS Quality Management, in advance, of the following major changes:

1) Major leadership or staffing changes.
2) Major organizational and/or corporate structure changes (example: conversion to non-profit status).

3) Any changes in the types of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.
4) Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).
5) Change of ownership or location.
6) Complaints regarding the provider.

12. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to BHRS Quality Management (via fax # 650-525-1762) when there are unusual events, accidents, errors, violence or significant injuries requiring medical treatment for clients, staff or members of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

The incident reports are confidential however discussion may occur with the Contractor regarding future prevention efforts to reduce the likelihood of recurrence. Contractor is required to participate in all activities related to the resolution of critical incidents.

13. Ineligible Employees

Behavioral Health and Recovery Services (BHRS) requires that contractors comply with Federal requirements as outlined in 42 CFR (438.608) Managed Care Regulations. Contractors must identify the eligibility of employees, interns, or volunteers prior to hiring and on a monthly basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting Form, Policy#93-11) should a current employee, intern, or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns, and volunteers by following procedures included in BHRS Policy # 04-01, which can be found online at: http://www.smchealth.org/bhrs-policies/compliance-policy-funded-services-provided-contracted-organizational-providers-04-01. BHRS Quality Management must be notified within twenty-four (24) hours of any violations. Contractor must notify BHRS Quality Management if an employee's license is not current or is not in

good standing and must submit a plan to correct to address the matter.

a. Credentialing Check – Initial
During the initial contract process, BHRS will send a packet of contract documents that are to be completed by the Contractor and returned to BHRS. Attachment F – Agency/Group Credentialing Information will be included in the contract packet. Contractor must complete Attachment F and return it along with all other contract forms.

b. Credentialing Check – Monthly
Contractor will complete Attachment F – Agency/Group Credentialing Information each month and submit the completed form to BHRS Quality Management via email at: HS_BHRS_QM@smcgov.org or via a secure electronic format.

14. Compliance Plan and Code of Conduct

Contractor will annually read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct located at http://smchealth.org/bhrs-documents. In addition, Contractor will assure that Contractor's workforce is aware of compliance mandates and informed of the existence and use of the BHRS Compliance Improvement Hotline (650) 573-2695.

Contractor is required to conduct, complete and maintain record of annual compliance training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

15. Fingerprint Compliance

Contractor certifies that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Contractor shall have a screening process in place to ensure that employees who have positive fingerprints shall:

1. Adhere to CCR Title 9 Section 13060 (Code of Conduct) when providing services to individuals with whom they have contact as a part of their employment with the contractor; OR

2. Obtain an exemption from Community Care Licensing allowing the employee to provide services to individuals with whom they have contact as a part of their employment with the contractor.

A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

16. Staff Termination

Contractor shall inform BHRS, in a timely fashion, when staff have been terminated. BHRS Quality Management requires prompt notification to be able to terminate computer access and to safeguard access to electronic medical records by completing the BHRS Credentialing form.

17. Minimum Staffing Requirements

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

B. Cultural Competency

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

1. Contractor will submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of clients, families and the workforce. This plan will be submitted to the BHRS Analyst/Program Manager and the Health Equity Initiatives Manager (HEIM) by September 30th of the fiscal year.

The annual cultural competence plan will include, but is not limited to the following:

a. Implementation of policies and practices that are related to promoting diversity and cultural competence, such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.

b. Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee, grievance, or conflict resolution committee).

c. Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.

d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.)

e. Contractor will ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

2. Contractor will actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend the Cultural Competence Council (CCC) for the term of the Agreement. Participation in the CCC allows for the dissemination of CLAS as well as ongoing collaborations with diverse stakeholders. Contractor shall submit to BHRS Office of Diversity and Equity (ODE) by March 31st, a list of staff who have participated in these efforts. For more information about the CCC, and other cultural competence efforts within BHRS, contact HEIM.

3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If Contractor is unable to provide services in those languages, Contractor is expected to contact Access Call

Center or their BHRS Analyst/Program Manager for consultation. If additional language resources are needed, please contact HEIM.

4. Contractor will translate relevant and appropriate behavioral health-related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner. BHRS strongly encourages its contractors to use BHRS-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to HEIM by March 31st, copies of Contractor's health-related materials in English and as translated.

5. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the BHRS Analyst/Program Manager and HEIM at ode@smcgov.org to plan for appropriate technical assistance.

D. Availability and Accessibility of Service

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

E. Surety Bond

Contractor shall retain and show proof of a bond issued by a surety company in accordance with Community Care Licensing's regulations for a licensee who may be entrusted with care and/or control of client's cash resources.

VII. GOALS AND OBJECTIVES / REPORTING

A. MHSA FSP

1. Goals and Objectives

Goal One:	Contractor shall implement wellness and recovery action plans (WRAP)
Objective One:	Fifty percent (50%) of FSP enrollees will have WRAP within 12 months of enrollment.

Data to be collected by Contractor.

Goal Two: Decrease incarceration of clients needing mental health services. (FSP)

Objective One: Enrolled program consumers shall reduce total days of incarceration by seventy percent (70%) in comparison to total days for twelve (12) months prior to enrollment.

Data to be collected by Contractor.

Goal Three: Decrease hospitalization of enrolled consumers.

Objective One: Enrolled program consumers shall reduce total days of hospitalization by seventy percent (70%) in comparison to total days for twelve (12) months prior to enrollment.

Data to be collected by Contractor.

Goal Four: Consumers shall be maintained in stable housing. (Housing)

Objective One: Sixty percent (60%) of consumers who live in supported housing will remain in stable housing at least one (1) year.

Data to be collected by Contractor.

Objective Two: Ninety percent (90%) of consumers satisfied with property management services. (Housing).

Data to be collected by Contractor.

2. Reporting

a. MHSA Reporting

Contractor shall comply with all State Department of Mental Health reporting requirements for Mental Health Services Act (MHSA) Full Service Partnerships including collections using State instruments, maintenance according to State guidelines, and reporting using State processes. Data collected will include but are not to be limited to:

i. Client's Satisfaction
ii. Medical/Psychiatric Hospitalization

iii. Residential Status
iv. Employment
v. Incarceration
vi. Emergency Room Contacts
vii. Financial Status
viii. Legal Events
ix. Monthly status reports including enrollments, dis-enrollments, jail, locked and twenty-four (24) hour placements.

b. Measure K Reporting

Contractor will report on performance measures and budget on a semi-annual basis, at fiscal mid-year and fiscal year-end. The data collected for the semi-annual reports shall include (but not be limited to) the following:

i. Number of clients served
ii. Client demographics – including address or zip code
iii. Narrative describing program outcomes and status of performance towards goals
iv. Any other information as directed by BHRS Program Manager

B. Criminal Justice Realignment (CJR) FSP Goals

Goal One: Contractor shall implement wellness and recovery action plans

Objective One: Fifty percent (50%) of CJR FSP enrollees will have WRAP within twelve (12) months of enrollment.

Data to be collected by Contractor.

Goal Two: Decrease incarceration of consumers.

Objective One: Enrolled program consumers shall reduce total days of incarceration by fifty percent (50%) in comparison to total days for twelve (12) months prior to enrollment.

Data to be collected by Contractor.

Goal Three: Decrease hospitalization of consumers.

Objective One: Enrolled program consumers shall reduce total days of hospitalization by seventy percent (70%) in

comparison to total days for twelve (12) months prior to enrollment.

Data to be collected by Contractor.

Goal Four: Consumers shall be maintained in stable housing.

Objective One: Sixty percent (60%) of consumers who live in supported housing will remain in stable housing at least one (1) year.

Data to be collected by Contractor.

Objective Two: Ninety percent (90%) of consumers satisfied with property management services. (Housing)

Data to be collected by Contractor.

*** END OF EXHIBIT A2 ***

EXHIBIT B2 – PAYMENTS AND RATES
TELECARE CORPORATION
FULL SERVICE PARTNERSHIP
FY 2019 – 2021

County and Contractor hereby agree to amend this agreement to incorporate necessary language to meet Federal and State requirements during the term of this agreement.

In consideration of the services provided by Contractor in Exhibit A2, County shall pay Contractor based on the following fee schedule:

I. Payments

A. Notwithstanding the method of payment set forth herein, in no event shall the maximum obligation that County shall pay or be obligated to pay Contractor for Full Service Partnership Services (FSP) and Housing Support Programs provided under this Agreement exceed TWELVE MILLION NINETY-FOUR THOUSAND SIX HUNDRED FORTY-FIVE DOLLARS ($12,094,645) for the term of the agreement.

B. In consideration of the services to be provided by Contractor, payment by County to Contractor shall be subject to the annual Cost Settlement process defined in Paragraph I.K. of this Exhibit B2.

C. Payment for the period of July 1, 2019 – June 30, 2020 (Year 1)

For the term July 1, 2019 through June 30, 2020, the maximum payment shall not exceed FIVE MILLION NINE HUNDRED SIXTEEN THOUSAND SEVEN HUNDRED FORTY-FIVE DOLLARS ($5,916,745).

1. Payment for FSP Services

The payment for the FSP services described in Exhibit A2 of this agreement for the period of July 1, 2019 through June 30, 2020 of this Agreement shall not exceed THREE MILLION EIGHT HUNDRED SEVENTY-EIGHT THOUSAND FIVE HUNDRED NINETY-FIVE DOLLARS ($3,878,595).

a. Base Caseload Amount (FSP) Payment

1) The FSP will cover service costs for TWO HUNDRED SEVEN (207) enrollees at the service levels as follows:

Service Level	Maximum # of enrollees

Intensive	167
Case Management	30
Wellness & Recovery	10
Total	207

2) In no event shall the total obligation of the County for FSP payments for this period exceed THREE MILLION EIGHT HUNDRED SEVENTY-EGHT THOUSAND FIVE HUNDRED NINETY-FIVE DOLLARS ($3,878,595).

3) Unless otherwise authorized by the Chief of San Mateo County Health or designee, and/or as adjusted subject to Paragraph I.C.1.a.2) of this Exhibit B2, the monthly rate of payment by County to Contractor shall be one-twelfth (1/12) of the FSP. Payments will be made in the amount of THREE HUNDRED TWENTY-THREE THOUSAND TWO HUNDRED SIXTEEN DOLLARS AND TWENTY-FIVE CENTS ($323,216.25) per month for this period of the Agreement. The amount of the monthly payment is subject to reduction as described in Paragraph I.C.1.a.5).

4) The FSP for this period of the Agreement includes: 1) MHSA funding, including flexible funds, in the amount of TWO MILLION FIVE THOUSAND THREE HUNDRED EIGHTY DOLLARS ($2,005,380) and County General funds in the amount of ONE HUNDRED SEVENTY-EIGHT THOUSAND THREE HUNDRED FIFTY-NINE DOLLARS ($178,359); and 2) the revenues expected to be generated by third-party billings: Medi-Cal Federal Financial Participation (FFP), Medicare and other applicable third-party payors for FSP services provided to enrollees (i.e. "Revenue Component"). The projected Revenue Component for FY 2019-20 is ONE MILLION THREE HUNDRED SEVENTY-SIX THOUSAND FIFTEEN DOLLARS ($1,376,015).

5) County and Contractor agree that in the event that the actual revenues collected for Contractor's services for this period are less than the Revenue Component and that difference is shown to have been generated by failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); 3) to provide services at a per unit cost that is equal to or below the State Maximum Allowance; or 4) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third-Party Disallowances"), the FSP may be reduced by the amount of that difference. In determining the amount of such reduction, the Third-Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement. The County shall determine the actual revenue generation. Any such reduction may, at the sole discretion of the County, result in a corresponding 1/12th payment reduction based upon the revised Revenue Component estimate of actual revenues available at that time.

b. Revenue Component reductions as described in I.D.1.a.5) of this Exhibit B2 shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph II.M. of Exhibit A2.

2. Housing Support Program

The total obligation of the County for Contractor's expenses for Housing Support Program costs for the period beginning July 1, 2019 through June 30, 2020, shall not exceed ONE MILLION FIVE HUNDRED FORTY-NINE THOUSAND NINE HUNDRED EIGHTY-EIGHT DOLLARS ($1,549,988).

a. Housing costs for this period shall not exceed a maximum of SEVEN HUNDRED SIXTY-NINE THOUSAND FOUR HUNDRED SIX DOLLARS ($769,406). Payment for housing costs will be made for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

b. Program administration and related expenses for this period shall be SIX HUNDRED EIGHTY-EIGHT THOUSAND ONE HUNDRED FORTY-THREE DOLLARS ($688,143). For this period monthly payments will be in the amount of FIFTY-SEVEN THOUSAND THREE HUNDRED FORTY-FIVE DOLLARS ($57,345).

c. Illinois House

The maximum amount that County shall be obligated to pay for services at the Illinois House for this period shall not exceed THIRTY-SEVEN THOUSAND EIGHTY DOLLARS ($37,080).

i. Contractor shall be paid at a rate of ONE THOUSAND EIGHT HUNDRED FIFTY-FOUR DOLLARS ($1,854) for six (6) dedicated beds. Payment will be made for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs

3. Criminal Justice (CJ) Full Service Partnership (FSP)

Payment for the services described in Exhibit A2.III shall not exceed FOUR HUNDRED EIGHTY-EIGHT THOUSAND ONE HUNDRED SIXTY-TWO DOLLARS ($488,162) for the period July 1, 2019 through June 30, 2020.

a. FSP Services and Housing Costs

FSP services and housing costs will be limited to a maximum of FOUR HUNDRED TWENTY-EIGHT THOUSAND SIX HUNDRED EIGHTY-FOUR DOLLARS ($428,684).

Base Caseload Amount (FSP)

Service Level	Annual Rate Per Enrollee	# Slots	Maximum Monthly Amount
Intensive	$23,545	5	$9,811
Community Case Mgmt	$18,856	3	$4,714
Total FSP			$17,862

The monthly payment by County to Contractor for FSP shall be SEVENTEEN THOUSAND EIGHT HUNDRED SIXTY-TWO DOLLARS ($17,862).

b. Case Rate Amount (CRA)

Service Level	Annual Rate Per Enrollee	# Slots	Maximum Monthly Amount
Intensive	$23,545	8	$15,698
Community Case Mgmt	$18,856	3	$ 4,714
Total CRA			$20,412

The monthly CRA rate shall be paid for any client that is enrolled during the month.

c. Housing Funds

Expenses related to client housing items and rent for those eligible to receive benefits, including General Assistance, will be reimbursed up to a maximum of FIFTY-NINE THOUSAND FOUR HUNDRED SEVENTY-NINE DOLLARS ($59,479) upon submission of invoices with proper supporting documentation.

4. Dedicated Emergency Single Room Occupancy Rooms

County shall pay for four (4) dedicated emergency single room occupancy rooms at SEVEN HUNDRED NINETY-SIX DOLLARS ($796) per room per month or for a maximum of THREE THOUSAND ONE HUNDRED EIGHTY-THREE DOLLARS ($3,183) per month not to exceed a maximum amount of THIRTY-EIGHT THOUSAND ONE HUNDRED NINETY-TWO DOLLARS ($38,192) for the period July 1, 2019 through June 30, 2020.

5. Special Circumstances Housing Placement

The maximum payment for Special Circumstances Housing Placement shall not exceed SEVENTEEN THOUSAND ONE HUNDRED SIXTY-SEVEN DOLLARS ($17,167) for the term July 1, 2019 through June 30, 2020.

D. Payment for the period of July 1, 2020 – June 30, 2021 (Year 2)

For the period July 1, 2020 through June 30, 2021, the maximum payment shall not exceed SIX MILLION ONE HUNDRED SEVENTY-SEVEN THOUSAND NINE HUNDRED DOLLARS ($6,177,900).

1. Payment for FSP Services

The maximum payment for FSP services for the period July 1, 2020 through June 30, 2021 shall not exceed FOUR MILLION ONE HUNDRED NINETEEN THOUSAND FIVE HUNDRED EIGHTY-FIVE DOLLARS ($4,119,585).

a. FSP Services

1) The FSP will cover service costs for TWO HUNDRED SEVEN (207) enrollees at the service levels as follows:

Service Level	Maximum # of enrollees
Intensive	177
Case Management	30
TOTAL:	207

2) In no event shall the total obligation of the County for FSP payments for this period exceed FOUR MILLION ONE HUNDRED NINETEEN THOUSAND FIVE HUNDRED EIGHTY-FIVE DOLLARS ($4,119,585).

3) Unless otherwise authorized by the Chief of San Mateo County Health or designee, and/or as adjusted subject to Paragraph I.C.1.a.2) of this Exhibit B2, the monthly rate of payment by County to Contractor shall be one-twelfth (1/12) of the FSP. Payments will be made in the amount of THREE HUNDRED FORTY-THREE THOUSAND TWO HUNDRED NINETY-EIGHT DOLLARS AND SEVENTY-FIVE CENTS ($343,298.75) per month for this period of the Agreement. The amount of the monthly payment is subject to reduction as described in Paragraph I.C.1.a.5).

4) The FSP for this period of the Agreement includes: 1) MHSA funding, including flexible funds, in the amount of TWO MILLION FIVE THOUSAND THREE HUNDRED EIGHTY DOLLARS ($2,005,380) and County General funds in the amount of ONE HUNDRED SEVENTY-EIGHT THOUSAND THREE HUNDRED FIFTY-NINE DOLLARS ($178,359); and 2) the revenues expected to be generated by third-party billings: Medi-Cal Federal Financial Participation (FFP), Medicare and other applicable third-party payors for FSP services provided to enrollees (i.e. "Revenue Component"). The projected Revenue Component for FY 2020-21 is ONE MILLION THREE HUNDRED SEVENTY-SIX THOUSAND FIFTEEN DOLLARS ($1,376,015).

5) County and Contractor agree that in the event that the actual revenues collected for Contractor's services for this period are less than the Revenue Component and that difference is shown to have been generated by failure to bill and/or disallowances by third party payors based on Contractor's failure: 1) to use Medicare-eligible providers; 2) to provide documentation adequate to support Contractor's services per County BHRS Documentation Manual (incorporated by reference herein); 3) to provide services at a per unit cost that is equal to or below the State Maximum Allowance; or 4) to submit the billing information required by this Agreement to the County in a timely manner (collectively, "Third-Party Disallowances"), the FSP may be reduced by the amount of that difference. In determining the amount of such reduction, the Third-Party Disallowances shall be subtracted from the amount of gross revenues collected by County for Contractor's services under this Agreement. The County shall determine the actual revenue generation. Any such reduction may, at the sole discretion of the County, result in a corresponding one-twelfth (1/12) payment reduction based upon the revised Revenue Component estimate of actual revenues available at that time.

b. Revenue Component reductions as described in I.C.1.a.5) of this Exhibit B2 shall not relieve Contractor of the obligation to provide the volume of services as described in Paragraph II.M. of Exhibit A2.

2. Housing Support Program

The total obligation of the County for Contractor's expenses for Housing Support Program costs for the period beginning July 1, 2020 through June 30, 2021, shall not exceed ONE MILLION FOUR HUNDRED NINETY-FOUR THOUSAND SIX HUNDRED TWENTY-NINE DOLLARS ($1,494,629).

a. Housing costs for this period shall not exceed a maximum of SEVEN HUNDRED SIXTY-NINE THOUSAND FOUR HUNDRED SIX DOLLARS ($769,406). Payment for housing costs will be made for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

b. Program administration and related expenses for this period shall be SIX HUNDRED EIGHTY-EIGHT THOUSAND ONE HUNDRED FORTY-THREE DOLLARS ($688,143). For this period monthly payments will be in the amount of FIFTY-SEVEN THOUSAND THREE HUNDRED FORTY-FIVE DOLLARS ($57,345).

c. Illinois House

The maximum amount that County shall be obligated to pay for services at the Illinois House for this period shall not exceed THIRTY-SEVEN THOUSAND EIGHTY DOLLARS ($37,080).

i. Contractor shall be paid at a rate of ONE THOUSAND EIGHT HUNDRED FIFTY-FOUR DOLLARS ($1,854) for six (6) dedicated beds. Payment will be made for actual costs upon receipt of invoice from Contractor. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

3. Criminal Justice Full Service Partnership (FSP)

Payment for the services described in Exhibit A2.III. shall not exceed FIVE HUNDRED EIGHT THOUSAND THREE HUNDRED TWENTY-SEVEN DOLLARS ($508,327) for the period July 1, 2020 through June 30, 2021.

a. FSP Services and Housing Costs

FSP services and housing costs will be limited to a maximum of FOUR HUNDRED FORTY-EIGHT THOUSAND EIGHT HUNDRED FORTY-EIGHT DOLLARS ($448,848)

Base Caseload Amount (FSP)

Service Level	Annual Rate	# Slots	Monthly Amount
Intensive	$23,545	5	$9,811
Community Case Management	$18,856	3	$4,714
Total BCS:			$18,702

The monthly payment by County to Contractor for FSP shall be EIGHTEEN THOUSAND SEVEN HUNDRED TWO DOLLARS ($18,702).

b. Case Rate Amount (CRA)

Service Level	Annual Rate	# Slots	Monthly Amount
Intensive	$23,545	8	$15,698
Community Case Mgmt	$18,856	3	$ 4,714
Total CRA:			$20,412

The monthly CRA rate shall be paid for any client that is enrolled during the month.

c. Housing Funds

Expenses related to client housing items and rent for those eligible to receive benefits, including General Assistance, will be reimbursed up to a maximum of FIFTY-NINE THOUSAND FOUR HUNDRED SEVENTY-NINE DOLLARS ($59,479) upon submission of invoices with proper supporting documentation.

4. Dedicated Emergency Single Room Occupancy Rooms

County shall pay for four (4) dedicated emergency single room occupancy rooms at SEVEN HUNDRED NINETY-SIX DOLLARS ($796) per room per month or for a maximum of THREE THOUSAND ONE HUNDRED EIGHTY-THREE DOLLARS ($3,183) per month not to exceed a maximum amount of THIRTY-EIGHT THOUSAND ONE HUNDRED NINETY-TWO DOLLARS ($38,192) for the period July 1, 2020 through June 30, 2021.

5. Special Circumstances Housing Placement

The maximum payment for Special Circumstances Housing Placement shall not exceed SEVENTEEN THOUSAND ONE HUNDRED SIXTY-SEVEN DOLLARS ($17,167) for the term July 1, 2020 through June 30, 2021.

F. County Revenue Component Estimates

Contractor shall provide the minimum Medi-Cal and Medicare reimbursable services which shall generate the amounts of revenue for FSP as established below. These services shall be reported to County through the Monthly Reporting process as described in paragraph I.P. of this Exhibit B2.

	July 1, 2019 – June 30, 2020	July 1, 2020 – June 30, 2021
FSP	$1,376,015	$1,376,015

G. Operating Income

The Gross Operating Income described in Exhibit C (Budget) shall not exceed the amounts established in the table below without the express written consent of the Chief of San Mateo County Health. Funding for such Gross Operating Income is included in the Maximum Obligation set forth in Exhibit B2, Paragraph I.A. and County shall not pay nor be obligated to pay additionally for such Gross Operating Income.

Period	Amount
FY 2019-20 (Year 1)	$216,397
FY 2020-21 (Year 2)	$226,577
Total	$442,974

H. Contractor's Budget

1. Contractor's annual budget for these services for Fiscal Years 2019-21 is incorporated into this Agreement as Exhibit C. The allocation of funding for the Adult and Older Adult/Medically Fragile FSPs and Housing Support Programs shall be provided according to the Contractor's budget.

2. Contractor shall be responsible for all expenses incurred during the performance of services rendered under this Agreement that are not included in Exhibit C.

I. Budget modifications may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Paragraph 3.

J. The Chief of San Mateo County Health or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than $25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

K. Contractor shall maintain all program fiscal records to maintain current and future requirements for MHSA funded FSP services as determined by the State DMH, and as requested by the County.

L. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing services under the terms of this Agreement through the end of the contract period without further payment from County.

M. In the event this Agreement is terminated prior to June 30, 2021, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such

billing shall be subject to the approval of the Chief of San Mateo County Health or designee.

N. Disallowances that are attributable to an error or omission on the part of County shall be the responsibility of County. This shall include but not be limited to quality assurance (QA) audit disallowances as a result of QA Plan error or format problems with County-designed service documents.

O. The contracting parties shall be subject to the examination and audit of the Department of Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

P. Monthly Invoice and Payment

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

   a. Direct Services/Claims

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

   b. Indirect Services/Claims

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

2. Payment by County to Contractor shall be monthly. Claims that are received after the tenth (10th) working day of the month are considered to be late submissions and may be subject to a delay in payment. Claims that are received 180 days or more after the date of service are considered to be late claims. County reserves the right to deny invoices with late claims or claims for which completed service

reporting forms or electronic service files are not received. Claims may be sent to:

County of San Mateo
Behavioral Health and Recovery Services
2000 Alameda de las Pulgas, Suite 280
San Mateo, CA 94403

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

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

S. Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the Quality Improvement Manager of San Mateo County BHRS.

T. Inadequate Performance

If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, to review documentation, billing and/or other reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies. This Agreement may be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 5 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

U. Election of Third Party Billing Process

Contractor shall select an option for participating in serial billing of third-party payors for services provided through this Agreement through the completion of Attachment C – Election of Third Party Billing Process. The completed

Attachment C shall be returned to the County with the signed Agreement. Based upon the option selected by the Contractor the appropriate following language shall be in effect for this Agreement.

1. Option One

   a. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. Within ten (10) days of the end of each month, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph R of this Exhibit B2. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.

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

2. Option Two

   a. Contractor shall provide information to County so that County may bill applicable other third-parties before billing Medi-Cal for services provided by Contractor through this Agreement. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph R of this Exhibit B2. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently

makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement through the Cost Report reconciliation.

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

V. Beneficiary Billing

Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract except to collect other health insurance coverage, share of cost and co-payments. The Contractor shall not hold beneficiaries liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, referral or other arrangement rather than from the County, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

Contractor shall maintain all program fiscal records to maintain current and future requirements for MHSA funded FSP services as determined by the State DMH, and as requested by the County.

W. Cost Report/Unspent Funds

1. Contractor shall submit to County a year-end cost report no later than August 15th after the end of the fiscal year. Contractor shall submit to County a year-end single audit report no later than November 15th after the end of the fiscal year. Contractor shall annually have its books of accounts audited by a Certified Public Accountant and a copy of said audit report shall be submitted along with the Cost Report.

2. If the annual Cost Report provided to County shows that total payment to Contractor exceeds the total actual costs for all of the services rendered by Contractor to eligible patients during the reporting period, a single payment in the amount of the contract savings shall be made to County by Contractor, unless otherwise authorized by the BHRS Director or designee. By mutual agreement of County and Contractor, contract savings or "unspent funds" may be retained by Contractor and expended the following year, provided that these funds are expended for SUD services approved by County and are retained in accordance with the following procedures.

   a. Contractor shall submit a summary calculation of any savings ninety (90) days after end of the fiscal year. The summary calculation will be a separate report from the year-end cost report. With the summary calculation Contractor shall return the amount of the savings.

   b. At the time of the submission of the summary calculation Contractor may request to rollover some or all of any savings. The request must be made in writing to the BHRS Director or designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget. Savings shall not be spent until Contractor receives a written approval of the request. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved.

   c. If the specific purpose is not yet complete as of the end of the succeeding fiscal year, contractor may request to rollover the unspent funds to the succeeding second fiscal year by submitting a written request with the accounting report. The unspent rollover funds shall not be spent until the request is approved by the BHRS Director or designee.

   d. A final accounting of the rollover funds shall be submitted ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the second fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

X. Claims Certification and Program Integrity

1. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as

published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A2 of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

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

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

   Executed at _____ California, on _____20___

   Signed _____ Title _____

   Agency _____ "

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

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

   b. The beneficiary was eligible to receive services described in Exhibit A2 of this Agreement at the time the services were provided to the beneficiary.

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

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

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

   f. For each beneficiary with specialty mental health services included in the claim, all requirements for Contractor payment

authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

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

4. Except as provided in Paragraph VI.A.4. of Exhibit A2 relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

*** END OF EXHIBIT B2 ***

Telecare Corporation
San Mateo Tansitions FY 20 & 21 Budget Exhibit
5/4/2020

Fiscal Year 2020

	Total FSP	Total MHSA Housing Passthrough	Total AB109	Total AB109 Housing Passthrough	Total
Program Costs					
Wages	2,119,655	-	197,890	-	2,317,545
Benefits	667,213	-	62,291	-	729,504
FSP Housing	-	1,438,329	-	-	1,438,329
AB109 Housing	-	-	-	77,607	77,607
Other Member Expenses	34,444	-	3,216	-	37,660
Community/Clinical	498,679	-	46,557	-	545,236
Physical Plant	34,577	-	3,228	-	37,805
General & Administrative	292,147	-	27,275	-	319,422
Medical Records	457	-	43	-	500
Property	309,118	-	28,859	-	337,977
Ancillary	2,104	-	196	-	2,300
Corporate Allocation @ 11%	435,423	-	40,651	-	476,074
Operating Income @ 5%	197,920	-	18,478	-	216,397
Total Costs	4,591,738	1,438,329	428,683	77,607	6,536,357
Non-County Revenue					
FFP	1,376,015	-	-	-	1,376,015
Medicare	75,887	-	-	-	75,887
FSP Housing Client SOC	-	576,484	-	-	576,484
AB109 Housing Client SOC	-	-	-	18,128	18,128
Total Non-County Revenue	1,451,902	576,484	-	18,128	2,046,514
County Obligation					
FSP Funding	2,451,693	-	-	-	2,451,693
AB109 Funding	-	-	428,683	-	428,683
FSP Housing Administration	688,143	-	-	-	688,143
FSP MHSA Housing	-	769,406	-	-	769,406
AB109 Housing	-	-	-	59,479	59,479
Emergency Housing Passthrough	-	38,192	-	-	38,192
Illinois House	-	37,080	-	-	37,080
Special Circumstance Housing	-	17,167	-	-	17,167
Total County Obligation	3,139,836	861,845	428,683	59,479	4,489,843
San Mateo Contract Maximum	4,591,738	861,845	428,683	59,479	5,941,745

Fiscal Year 2021

	Total FSP	Total MHSA Housing Passthrough	Total AB109	Total AB109 Housing Passthrough	Total
Program Costs					
Wages	2,119,655	-	197,890	-	2,317,545
Benefits	667,213	-	62,291	-	729,504
FSP Housing	-	1,413,329	-	-	1,413,329
AB109 Housing	-	-	-	77,607	77,607
Other Member Expenses	34,444	-	3,216	-	37,660
Community/Clinical	498,679	-	46,557	-	545,236
Physical Plant	57,869	-	5,403	-	63,272
General & Administrative	292,147	-	27,275	-	319,422
Medical Records	457	-	43	-	500
Property	472,025	-	44,068	-	516,093
Ancillary	2,104	-	196	-	2,300
Corporate Allocation @ 11%	455,905	-	42,563	-	498,468
Operating Income @ 5%	207,230	-	19,347	-	226,577
Total Costs	4,807,728	1,413,329	448,848	77,607	6,747,512
Non-County Revenue					
FFP	1,376,015	-	-	-	1,376,015
Medicare	75,887	-	-	-	75,887
FSP Housing Client SOC	-	576,484	-	-	576,484
AB109 Housing Client SOC	-	-	-	18,128	18,128
Total Non-County Revenue	1,451,902	576,484	-	18,128	2,046,514
County Obligation					
FSP Funding	2,667,683	-	-	-	2,667,683
AB109 Funding	-	-	448,848	-	448,848
FSP Housing Administration	688,143	-	-	-	688,143
FSP MHSA Housing	-	744,406	-	-	744,406
AB109 Housing	-	-	-	59,479	59,479
Emergency Housing Passthrough	-	38,192	-	-	38,192
Illinois House	-	37,080	-	-	37,080
Special Circumstance Housing	-	17,167	-	-	17,167
Total County Obligation	3,355,826	836,845	448,848	59,479	4,700,998
San Mateo Contract Maximum	4,807,728	836,845	448,848	59,479	6,152,900