AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND CAMINAR, INC.

THIS AMENDMENT TO THE AGREEMENT, entered into this _____ day of _____, 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and CAMINAR, INC., hereinafter called "Contractor";

W I T N E S S E T H:

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

WHEREAS, the parties entered into an Agreement on September 17, 2019 for substance use disorder treatment services, outpatient mental health services, and housing and housing-related mental health services, for the term July 1, 2019 through June 30, 2021, in an amount not to exceed $20,536,485; and

WHEREAS, the parties wish to amend the Agreement to terminate mild to moderate services authorized by the Mental Health Plan September 30, 2020, reduce Recovery Residence funding in FY 2020-21, and add technology supports for clients and families, increasing the amount by $37,072 to an amount not to exceed $20,573,555, 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 "A.1.1 and A.2.1," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B.1.1 and B.2.1." 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 TWENTY MILLION FIVE HUNDRED SEVENTY-THREE THOUSAND FIVE HUNDRED FIFTY-FIVE DOLLARS ($20,573,555).

2. Exhibit A.1 and A.2 is hereby deleted and replaced with Exhibit A.1.1 and A.2.1 attached hereto.

3. Exhibit B.1 and B.2 is hereby deleted and replaced with Exhibit B.1.1 and B.2.1

attached hereto.

4. All other terms and conditions of the agreement dated September 17, 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

CAMINAR, INC.

Mark Cloutier Digitally signed by Mark Cloutier Date: 2021.01.01 14:19:12 -08'00'

_____
Contractor's Signature

Date:_____

EXHIBIT A.1.1 – MENTAL HEALTH SERVICES
CAMINAR, INC.
FY 2019 – 2021

In consideration of the payments set forth in Exhibit B.1.1, Contractor shall provide the following services:

I. DESCRIPTION OF SERVICES TO BE PROVIDED BY CONTRACTOR

A. Rehabilitative Mental Health Services

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

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

3. Consumer choice and goals are important factors in determining appropriate and safe housing. Services and supports to assist consumers in safely maintaining housing are based on consumer needs and goals as well as the living environment. Single room occupancy is a highly valued housing choice by consumers and is emphasized in resource development and integrated service planning.

4. Psychiatric services, medication support and service, and medical oversight will be provided by contractor's Medication Clinic Director for Full Service Partnership (FSP), REACH, designated New Ventures consumers and Redwood House.

5. Contractor will coordinate or participate in periodic case conferences about consumers whose care is shared with County treatment teams. This includes, but is not limited, to consumers residing in Redwood House, Hawthorne House, Eucalyptus House, and those receiving case management from New Ventures. Coordination will include treatment plans, consumer progress, and discharge planning.

B. Services

Contractor shall provide the following services:

1. Crisis Residential Treatment Services;
2. Transitional Residential Treatment Services,
3. Adult Case Management Services programs:
   a. Intensive Case Management (REACH) and
   b. New Ventures Case Management (including Tehanan and Colma Ridge) which includes the Wellness and Recovery Action Partnership Program (WRAPP);
4. Rehabilitation Services (including Supported Education Services and Supported Employment Services);
5. Young Adult Independent Living Program (YAIL) case management services;
6. Supportive Housing Services; and Transportation.

These services shall be provided in a manner prescribed by the laws of California and in accord with the applicable laws, titles, rules and regulations, including quality improvement requirements of the Short-Doyle/Medi-Cal Program. Contractor shall comply with the "Airs" policy, process and procedures for Intake, Crisis Residential, Transitional Residential Services, REACH Intensive Case Management, YAIL, and New Ventures Case Management programs. This includes communication with Adult Resource Management when a non-San Mateo County Behavioral Health and Recovery Services (BHRS) consumer is interested in accessing services or residing in one of the residential or crisis facilities. The BHRS Documentation Manual ("County Documentation Manual") is included herein by reference. To the extent that there is inconsistency between a provision in the County Documentation Manual and this Agreement, the provisions of the County Documentation Manual shall prevail. All services are co-occurring capable, trauma-informed and recovery-oriented. All payments under this Agreement must directly support services specified in this Agreement. Contracted services are to include following:

1. Crisis Residential Treatment Services

Contractor shall provide a sixteen (16) bed, twenty-four (24) hour crisis residential treatment facility (at effective date of the Agreement herein known as "Redwood House") for consumers with serious mental illness (SMI) with mental health and co-occurring disorders. Contractor shall provide therapeutic and/or rehabilitation services in a structured program as an alternative to hospitalization or a step-down from hospitalization for consumers experiencing an acute psychiatric episode or crisis, and who do not present medical complications requiring nursing care. Contractor shall support consumers in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems, and will make available interventions which focus on symptom reduction and management and recovery.

a. Contractor will provide consumers admitted to the Crisis Residential Treatment Facility with a mental health assessment, and screen for substance use and trauma.

b. Ongoing Crisis Residential Treatment Services shall include assessment/evaluation, integrated, consumer-centered plan development, therapy/counseling, rehabilitative mental health services, dual diagnosis assessment and treatment for substance use, collateral services, and crisis intervention.

c. Contractor shall provide five thousand one hundred thirty-nine (5,139) consumer days of Crisis Residential Treatment Services (equating to 88% occupancy at Redwood House) to one hundred thirty-five (135) unduplicated consumers during the term of this Agreement. A "consumer day" shall mean any and all services rendered by Contractor on behalf of one (1) consumer during any single day during which the consumer was present in the Crisis Residential Treatment Facility.

d. Contractor shall welcome to the Crisis Residential Treatment Facility only those persons who are identified according to the following criteria:
    i. Persons in acute psychiatric distress and co-occurring disorders who require immediate supervised crisis residential treatment and who, in the absence of such community-based treatment, would require admission to full-time inpatient psychiatric services.
    ii. Minimally functioning consumers who require supervised housing on an emergency basis while awaiting specific placement within community facilities
    iii. Persons identified in section d.i. who are in a treatment readiness status who would benefit from individual

coaching and small group activities in preparation for the full rehab experience. Clients will be considered on a case by case basis.

e. BHRS Division Adult Resource Management, working closely with acute inpatient psychiatric emergency services and Contractor shall authorize persons for admission to the Crisis Residential Treatment Facility, and, in the case of multiple applications for admission, shall prioritize eligible persons for admission.

f. BHRS Division Adult Resource Management will work closely with the Crisis Residential Treatment Facility staff and will meet weekly for utilization review and management of consumers.

g. Psychiatrist services will be provided. Duties include psychiatric assessment, medication services, consumer groups, staff consultation, liaison with other psychiatrists and educate consumers with substance use issues how to take psychiatric medications safely. These services will be provided by psychiatric staff associated with contractors medication clinic described in section.B.3.h.

h. The Crisis Residential Treatment Facility will provide the following:
   i. The ability to admit more than one person per day to the Crisis Residential Treatment Facility.
   ii. The ability to admit some individuals from psychiatric emergency services:
      1) County will work together with Contractor to define which consumers are appropriate admissions from psychiatric emergency services.
      2) County Resource Management team will work with psychiatric emergency services to complete all forms required by Community Care Licensing prior to a consumer's admission to the Crisis Residential Treatment Facility.
   iii. A program structure that promotes life skills training, addresses co-occurring disorder issues via stage-matched substance abuse groups and mandatory group participation in at least three (3) to five (5) groups a day, seven (7) days a week.

2. Transitional Residential Treatment Services

Contractor shall provide two (2), twelve (12) bed, twenty-four (24) hour transitional residential treatment facilities for a total of twenty-four (24) beds for consumers with serious mental illness (SMI) with mental health and co-occurring disorders (each referred to as a "Transitional Residential Treatment Facility" or collectively "Transitional Residential Treatment Facilities"). As of the effective date of this Agreement, the Transitional Residential Treatment Facility beds are distributed between the facilities known and referred to herein as Hawthorne House ("Hawthorne House") with twelve (12) beds, and Eucalyptus House ("Eucalyptus House") with twelve (12) beds. Treatment and/or rehabilitation services shall be provided in a structured therapeutic community at each Transitional Residential Treatment Facility and shall include a range of activities and services for consumers who would be at risk of hospitalization, or other institutional placement, were they not in this residential program ("Transitional Residential Treatment Services"). Contractor shall support consumers in their efforts to restore, maintain and apply interpersonal and independent living skills, and to access and link to community support systems. Contractor shall also make available interventions which focus on symptom reduction.

a. Transitional Residential Treatment Services shall include co-occurring capable assessment/evaluation, integrated, consumer-centered plan development, individual and group counseling, rehabilitative behavioral health services, collateral services and crisis intervention.

b. Contractor shall provide seven thousand four hundred fifty-six (7,456) consumer days which is the sum of three thousand seven hundred twenty-eight (3,728) consumer days at Hawthorne House at eighty-five percent (85%) capacity, and three thousand seven hundred twenty-eight (3,728) consumer days at Eucalyptus House at eighty-five percent (85%) capacity. A "consumer day" shall be deemed to mean any and all Transitional Residential Treatment Services rendered by Contractor on behalf of one (1) consumer during any single day during which the consumer was present overnight at one of the Transitional Residential Treatment Facilities.

c. The expected length of stay at a Transitional Residential Treatment Facility is six (6) months. Lengths of stay exceeding six (6) months will require a treatment extension authorization from County.

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

e. Eucalyptus House Residential Transitional Program is a twenty-four (24)-hour Transitional Social Rehabilitation program. The program provides services to San Mateo County BHRS consumers age eighteen (18) to sixty-five (65), with a focus on serving Transition Age Youth (TAY), who are young adults between the ages of eighteen (18) and thirty (30). Eucalyptus house will continue to service consumers of all ages as needed, but the program will be designed primarily to meet the needs of a young adult population. Services and programming will focus on learning independent living skills for individuals transitioning into adulthood.

3. Case Management Services

a. Contractor shall provide strength-based case management services ("Case Management Services"). Such Case Management Services shall focus on consumer needs, strengths and choices, and shall involve the consumer in service planning and implementation. The goal of Case Management Services is to help consumers take charge of their own lives through informed decision making. Case Management Services shall assist the consumer in acquiring skills and support systems needed to function successfully in environments where they choose to live, learn, work and socialize.

b. Contractor shall staff two Case Management Services programs: 1) Intensive Case Management (REACH), and 2) New Ventures Case Management (New Ventures/Tehanan and Colma Ridge) which includes the Wellness and Recovery Action Partnership Program (WRAPP). Staffing for the two Case Management Services programs operated by Contractor shall be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation, and other social characteristics of the community served. Staff for both Case Management Services shall include both licensed and

non-licensed individuals who are trained to provide mental health services and welcome and address co-occurring disorders. The Case Management Services programs are described as follows:

c. Intensive Case Management (REACH)

i. Contractor shall provide Intensive Case Management Services for fifty-five (55) adults/older adults who are residents of San Mateo County and are SMI including those with co-occurring substance use issues. REACH 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.

ii. The REACH team will operate under policies and procedures that ensure:

1) 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. The emergency call number can be provided by a qualified third party.

2) Interventions with consumers are mostly face-to-face visits. Contact with each consumer will occur as often as clinically needed, which may be daily.

3) 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.

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

1) 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), REACH program staff will make phone contact with the locked facility within four (4) hours of knowledge of consumer arrival and make an initial visit with the consumer within twenty-four (24) hours of consumer entry.
2) Regular contact with the consumer and with inpatient treatment staff while the consumer is hospitalized. During these episodes, REACH will work with inpatient staff to make discharge recommendations and facilitate the consumer's return to the community.
3) Engagement during criminal justice contacts. REACH 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.
4) 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.

iv. REACH teams have final accountability for assuring the delivery of services and are responsible for service outcomes. REACH 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 REACH team will work in collaboration with the other service providers to assure implementation of the individualized plan.

v. REACH 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.

1) REACH 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.
2) REACH program staff will also participate in bi-monthly case conference meetings with BHRS and an annual review panel to assist in the management of the consumer level of care needs.
3) REACH 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.
4) REACH program staff will also communicate substantive changes in a consumers, 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.

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

vii. 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. REACH team members will work with individual consumers to arrange for delivery/prompts/reminders that will support regular scheduled medications.

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

ix. REACH 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. REACH 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.

x. 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.

1) The goal is to provide permanent independent housing throughout the community.
2) Housing resources will be available to consumers in this program in the form of rental subsidies for adults and older adults.
3) REACH housing resources for all age groups and will include a variety of levels of housing including independent, Board and Care, and supported housing.

xi. REACH 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.

xii. 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.

xiii. The Peer Partner will play a critical role, modeling personal recovery, helping consumers establish a network of peer, family, and cultural supports including, peer run self-help centers. One of the primary roles to be performed by the REACH team Peer Partners will be to establish peer relationships among REACH 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 consumer in the least restrictive environment.

xiv. Consumers will work with REACH 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.

xv. The REACH 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.

xvi. Supported education is another resource for REACH consumers. The REACH 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.

xvii. 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 or Board of Behavioral Science registered 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.

xviii. 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.

xix. REACH program staff will assess and arrange for services and supports as appropriate for each consumer based on a range of supports including:

1) Transportation and escorted services to assist at medical appointments and with other transportation needs.
2) 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.
3) Providing social supports and facilitating access to supports to address isolation and loneliness.

xx. The REACH 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. REACH will engage and empower natural community supports that will extend the impact of the REACH staff.

d. Admission, Discharge and Length of Stay

i. The BHRS REACH/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 REACH provider.

ii. Disagreements regarding referrals will ultimately be resolved by BHRS Deputy Director of Adult and Older Adult Services and Contractor's Director of Clinical Services.

iii. REACH will admit individuals referred to REACH by BHRS. Consumers will be referred for REACH services based on acuity and need for intensive level services based on the following criteria:

1) Three (3) PES/ED visits in last sixty (60) days; AND/OR
2) Two (2) inpatient psychiatric hospitalizations in last six (6) months with most recent hospitalization in past thirty (30) days; AND/OR
3) Transitioning out of a locked/secure facility (i.e. MHRC, Secured SNF, Jail, or Out of County Placement); AND/OR
4) Loss of current support system that would potentially result in hospitalization, incarceration or other form of locked placement without REACH level services based on past history.

iv. The BHRS REACH/FSP Review Committee will be convened as needed to ensure REACH slots are filled when they become available.

v. Transition planning begins at assessment, with step down planning as a part of the overall service plan. Cases will be discussed on an annual or as needed basis to determine consumer level of care needs and potential transition plans to another level of service.

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

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

viii. REACH 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 REACH level of care. Every opportunity will be given in advance for the consumer to be re-engaged before disenrollment, during which time the program will be responsible for continued outreach/engagement as well as linking the consumer to alternative services.

ix. Length of stay in the REACH program is determined by consumer level of care needs which will be assessed regularly by the REACH provider and formally discussed on an annual basis with at the case management meeting. REACH will develop and implement an internal system to review consumer level of care needs to assess when consumers may be ready to graduate from REACH services. Housing subsidies for REACH consumers may be managed as part of a separate contract for management of housing subsidy resources.

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

xi. 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 sixty (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 REACH program (for any reason) for more than forty-five (45) days.

e. REACH Supplemental Case Management at Central and North County

Contractor will provide Supplemental Case Management Services to fifteen (15) North County and seven (7) Central County consumers as described below:

i. Referrals will be accepted from Central and North County to provide intensive case management services to consumers who are open to the North County Regional Clinics.

ii. Regional case managers will develop the integrated plan of care to be implemented by the Contractor's case managers. Typical Case Management activities will be strength-based and recovery-oriented and will

include community based supportive visits, crisis response, assistance with activities of daily living, transportation assistance, and assistance with maintaining housing. Medication monitoring is included activity.

iii. Contractor will open the case and document and bill for Case Management services as appropriate.

iv. Contractor will participate in meetings with BHRS Regional Clinic teams to develop procedures as necessary and will assist in evaluation of the Case Management services to develop coordinated care.

v. Contractor shall provide one hundred twenty thousand (120,000) minutes of case management.

f. 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 thirty (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 verbal 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.

g. New Ventures Case Management (New Ventures/Tehanan and Colma Ridge) and Wellness and Recovery Action Partnership Program (WRAPP)

i. Contractor shall provide community-based case management services to an active caseload of two hundred thirty-four (234) SMI consumers with mental health and co-occurring disorders who are in the community (apartment, board and care home, hotel, etc.). Such Case Management shall be referred to as "New Ventures Case Management" or "New Ventures Case Management (New Ventures/Tehanan and Colma Ridge)". For New Ventures Case Management, Contractor shall maintain an approximate ratio of one (1) staff member to twenty-six (26) consumers. New Ventures Case Management shall include supportive counseling and coordination of resources (medical, psychiatric, social, vocational, educational and housing) necessary to enhance consumer's potential successful community living.

ii. As part of New Ventures Case Management, Contractor shall provide housing and support services at Tehanan and Colma Ridge, an apartment complex which provides supportive housing, for consumers who are able to live independently with support services.

iii. Contractor will develop a document detailing admission and discharge criteria and process for both Tehanan I and II and Colma Ridge.

iv. Services provided by on site case manager at Tehanan I and II shall include but are not limited to:

1) At least one (1) individual meeting with resident weekly. More if needed.
2) Assessment of daily living skills and assist resident to learn and improve skills to include cleaning, cooking, hygiene, personal health and safety.
3) Assistance with medical, psychiatric and other appointments.

4) Coordination and follow up with med support and med instructions.
5) Facilitation of roommate, house and community meetings to address issues of successful community living.
6) Work with residents, property management, and property owner on issues of habitability tenancy and safety.
7) Connect residents to community resources and meaningful activities.
8) Provision of Rep payee services to client in need of the service.

v. Services provided by offsite case manager to clients at Colma Ridge will include all of the above based on individual client assessment and need.

vi. Contractor shall provide seven hundred thirty-five thousand (735,000) minutes of New Venture Case Management.

vii. Contractor will provide additional services, described below, to a sub-population of the consumers to whom Contractor provides New Venture Case Management services. Such additional services are known as Wellness Recovery Action Partnership Program ("WRAPP") services. For WRAPP services Contractor shall maintain an approximate ratio of one (1) staff member to forty (40) consumers.

1) Participants in the WRAPP services will be identified using the following criteria:
   a) No hospitalizations within the last twelve (12) months.
   b) Demonstrated interest in preparing a wellness recovery action plan and participating in on-going groups and activities to support recovery.
2) Participants will accomplish the following goals:
   a) Prepare individual wellness recovery action plans.
   b) Work with a benefits consultant to develop plans for financial self-sufficiency.
   c) Work with Contractor's Job Plus and Supported Employment staff to develop employment and educational goals.
   d) Develop skills in learning how to access community resources independently.

e) Develop a social activities calendar with at least ten (10) activities per year.

f) Assess their level of need for on-going system of care services with the intention of developing exit strategies, i.e. obtaining medications from a network physician rather than a regional clinic.

3) Contractor shall insure that WRAPP participants meet individually and/or in groups to carry out the program objectives outlined above. All WRAPP activities will be coordinated by a single New Ventures Case Management manager who will have responsibility for participants in this program. Approximately ten (10) hours per week of WRAPP support will be provided by Contractor.

viii. A collaborative, active, utilization review process will be maintained. This process will ensure that consumers are seen at an appropriate level of service that matches their service needs and LOCUS level.

ix. Transition planning begins at assessment, with step-down planning as part of the overall service plan. BHRS and contractor will meet bi-monthly to discuss consumer level of care needs and potential transition plans to another level of care among contractors programs or discharge out of contractor services entirely.

x. The Wellness program will serve consumers needing minimal case management services and as a step-down from WRAPP for consumers receiving HUD subsidized housing, and/or consumers whose primary need is for psychiatric services will be seen by the WRAPP Case Manager at a ratio of three:one (3:1) regular WRAPP consumers. These ratios could create a WRAPP case load of up to sixty (60) consumers; defined as three (3) Wellness consumers which are the equivalent of one (1) WRAPP consumer in terms of the total WRAPP Program consumer capacity. Therefore, the total number of consumers in the overall WRAPP program, at any point in time, will vary depending on the breakdown in number of consumers receiving regular WRAPP level services and Wellness level of services.

h. Medication Clinic

Contractor will maintain psychiatric and nursing services that serve the clients from Caminar FSP (30 clients), REACH (55 clients), New Ventures (120 clients) and the Wellness clients who require medication. Services for the FSP clients and the funding for those clients are addressed in a separate contract. Psychiatric Services for Redwood House are addressed in Section 1.B 1. g.

Contractor will continue to analyze and restructure the Medication Clinic in order to improve an efficient and cost-effective quality of care of all clients served by contractors Medication clinic. Contractor will work with the BHRS Medical Director on improvements to the medication clinic plan.

i. Psychiatric Services
   1) An active case load of fifty-five (55) REACH consumers, one hundred twenty (120) New Ventures consumers and up to sixty (60) Wellness consumers will be maintained. An active consumer is defined as a person who had at least one face-to-face contract with a psychiatrist within the previous ninety days (90).
   2) At least ninety-five percent (95%) of all cases of consumers who have not received care with the previous ninety (90) day period shall be closed.

ii. Medication Support Services
   1) Contractor shall provide clinic and community-based medication support services ("Medication Support Services"). Such Medication Support Services shall include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness, and shall be provided by a staff person within the scope of practice of his/her profession.
   2) Contractor shall provide a minimum of one hundred twenty-five thousand (125,000) minutes of Psychiatric and Medication Support Services and maintain an active caseload of fifty-five (55) Reach clients and at least one hundred twenty (120) consumers. Wellness Consumers will be seen at a ratio of three:one (3:1) of regular case management consumers and will increase the total caseload accordingly.
   3) Eligibility for Medication Support Services shall be confined to persons who are in need of

medication support services as determined by a clinical assessment.

4) Contractor will maintain at a minimum the following medical staff for Reach, New Ventures and Wellness Clients:
   i) 1.20 FTE Psychiatrist (PNP)
   ii) 1.0 FTE RN
5) Contractor will provide direct and/or consultative Psychiatric services at Redwood House depending on the client level of functioning. Direct services will include a face-to-face meeting with clients who are not yet engaged, with ongoing psychiatric treatment and monitoring of such clients until they have completed the first appointment with the primary psychiatrist, or are discharged, whichever comes first. Contractor shall provide consultation including after hours as needed by Redwood House staff. Psychiatrist shall consult with staff on medication and treatment issues, and act as a liaison between the Primary Psychiatrists and Redwood House.
6) Contactor's Medical Director will meet monthly with the BHRS Medical Director.

4. Rehabilitation Services (Supported Employment Services, Training and Consulting, and Supported Education Services)

   a. Supported Employment Services
   Contractor shall provide two thousand one hundred eighty hours (2,180) annually supported employment and job placement services to San Mateo County adults who have been diagnosed with psychiatric disabilities and co-occurring disorders. Employment specialists assist consumers in preparing for employment and developing job skills. Job developers find positions for consumers in the business community. Once employment is secured, support is offered for the duration of the job. All consumers referred to Supported Employment Services, regardless of level of disability, will be offered employment services through Jobs Plus.
      i. Contractor will be an active participant in San Mateo County co-op with BHRS, Vocational Rehabilitation Services, and California Department of Rehabilitation.
      ii. Contractor will achieve all outcomes as stated in the annual Co-op agreement.

b. Supported Education Services

i. Contractor will provide case management and support services for a supported education program on the College of San Mateo campus to students with psychiatric disabilities and co-occurring disabilities. In addition, Contractor will teach three (3) specialized classes on a rotating basis throughout the year: Wellness and Recovery, Peer Counseling, and Advanced Peer Counseling.

ii. A minimum of two (2) supported education courses will be designed for and taught to adults with mental illness and co-occurring disorders each semester. The instructor will conduct an evaluation of each class at the end of the semester.

iii. Caminar will work in partnership with BHRS and College of San Mateo (CSM) to redesign the Supported Education Program to provide a stronger bridge into the standard curriculum.

iv. Contractor shall provide twelve thousand (12,000) minutes of Supported Education Services and Supported Employment Services (as described below) to one hundred (100) unduplicated adult consumers.

v. At least sixty-five percent (65%) of students enrolled in peer counseling classes will complete the course.

vi. Supported Education is fully funded by the federal SAMHSA block grant. Contractor will abide by all provisions of the SAMHSA block grant which is incorporated by reference through Attachments 2 and 3 of this Agreement

c. Enhanced Supported Education Services for Transitional Age Youth

i. Contractor will provide enhanced supported education services to approximately twenty (20) transition age youth (TAY) ages eighteen – twenty-five (18-25) referred by the FSP Provider (as defined in Paragraph I.B.4.b.ii below) and approximately twenty (20) TAY identified by Contractor. All such TAY shall have emotional and behavioral difficulties and TAY with co-occurring disorders will be welcomed. Outreach to TAY who are still in high-school or who have dropped out will be provided. The focus of these services will be to engage each TAY in educational or vocational activities that will lead to completion of educational plans and employment.

ii. Contractor shall work in partnership with the Mental Health Services Act ("MHSA") funded Full Service Partnership provider ("FSP Provider") who has been selected to provide TAY services.

iii. Delivery Components

1) Summer Academy: Contractor will provide a "Summer Academy" which will be a quasi-educational program to help students build their confidence and self-esteem so that they will have a better chance of being successful in school and employment. A team teaching model will be employed which utilizes peer counselors, a core instructor, case management services, and guest speaker/mentors.

2) Transition to College classes: Contractor will provide two "Transition to College" classes, in addition to the classes that the Contractor provides as described in Paragraph I.B.4.a. above.

3) Academic Counseling: Contractor will coordinate with Disabled Students Programs to provide a Master's level academic counseling intern to offer academic counseling, develop student individual educational plans (IEP), oversee completion of required DSPS paperwork, and provide personal support to TAY students.

4) Linkage to employment: Contractor will provide services that link students with employment services.

5) At least two hundred forty (240) engagement activities will be provided by Caminar annually. Engagement activities include in-program activities at partner agencies, social outings, and campus tours.

6) Caminar staff will provide at least six hundred fifty (650) contacts with TAY annually. Contacts consist of face-to-face and phone contacts for the purposes of engaging new program participants and supporting current students.

5. Young Adult Independent Living Program (YAIL) Services

a. Contractor shall provide co-occurring capable, intensive support services to twenty-five (25) TAY, six (6) of whom are residents of YAIL, ages eighteen – twenty-five (18-25) years.

YAIL services are welcoming to specific needs of the TAY population, recovery-oriented and include intensive case management with an emphasis on education, employment, and the development of independent living skills. Contractor shall provide participants with assistance with housing. Participants may reside in the community or in a 4-unit apartment complex located in Redwood City. Contractor shall provide on-site counseling staff to be available12 hours per day, seven (7) days a week for residents in such Redwood City apartment complex.

b. Contractor shall provide one hundred sixty-two thousand two hundred forty (162,240) minutes of YAIL services. Such minutes are calculated based on sixty-five percent (65%) of two (2) FTE's. For YAIL services Contractor shall maintain an approximate ratio of one (1) case manager to ten (10) consumers.

c. Contractor shall provide care coordination, including completion of all annual documentation for all YAIL residents unless there is existing care coordination at a regional clinic.

6. Supportive Housing

Contractor will provide supportive housing services to REACH, New Ventures and REACH FSP clients that include securing and maintaining all levels of housing that enable consumers to remain in the community with supportive services. Funding for FSP clients is addressed in a separate contract.

a. Contractor will work with consumers to secure 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. The 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.

The Contractor shall ensure the consumer has a housing component to their personal service plan and that skill acquisition and the consumer's living experience is the focus of case management services in order to keep the consumer housed in a setting where they can be successful.

b. County agrees and acknowledges that Contractor owns and leases property used to provide permanent and transitional housing for adults with SMI with mental health and co-occurring disorders.

c. Contractor will screen consumers for eligibility as property residents and provide Property Management services, which include assisting consumers in locating and acquiring safe affordable housing. Contractor's property management staff will help consumers negotiate rental agreements, mediate landlord-tenant issues and establish and maintain utilities. Contractor shall also lease and sublease apartments to consumers enabling them to establish a positive rental credit history.

d. Contractor's property management staff shall collect and pay rents. They will work with the Housing Authority to acquire, manage and maintain all Caminar Shelter Plus Care contracts. They shall help consumers acquire and maintain Section 8 housing vouchers, ensure basic household maintenance, perform rental unit inspections and when necessary, pursue a legal eviction.

e. Contractor's property management staff shall provide and maintain property liability insurance on all units.

f. Contractor's property management staff shall work closely with Contractor's case managers and peer counselors to provide an integrated support service with independent living skills training and access to community resources that enable consumers to maintain and retain their housing.

g. Contractor's property management staff will provide housing options and consumer choice which are vital service components in support of consumer self-determination and successful community integration.

h. Contractor shall maintain an MOU or contract with non-profit property management or property owners such as Mental Health Association and Mid-Peninsula Housing. The MOU/Contract will provide detail of the responsibilities of Caminar's supportive housing case management staff and property management staff. Processes and protocols will be included that address tenant issues that may impact the health, safety and habitability of tenant units and/or that may lead to housing instability.

i. Contractor will develop agreements with operators of Board and Care facilities and Room and Board facilities for rates of payment. Contractor will develop guidelines for the client portion and the contractor portion of the payment. Contractor will submit a monthly statement to the contract monitor on direct housing costs (rent, moving costs, deposits, etc.) for all clients subsidized in the REACH Housing expansion fund.

j. Contractor will work with BHRS to analyze the structure, staffing, staff responsibilities and budget for the Supportive Housing programs and make improvements as agreed upon.

7. Transportation

Contractor will manage the transportation needs of consumers in all Contractor-sponsored programs. Contractor will determine consumer's ability to use public transportation, Redi-wheels, staff-provided transportation or taxis. Contractor will provide orientation and training to consumers about transportation utilization when needed.

C. Mental Health Services (Authorized by the Mental Health Plan)

For the term July 1, 2019 through September 30, 2020, Contractor shall provide mental health services to clients under the San Mateo County Mental Health Plan (MHP). These services shall be provided to Medi-Cal eligible beneficiaries, clients who are covered by the Healthy Kids Programs, client caregivers who are covered by HealthWorx, clients who are covered by the Health Plan of San Mateo CareAdvantage program for Medicare, and clients known to be indigent, for whom the MHP has assumed responsibility. It is the Contractor's responsibility to ensure that the client is eligible at the time services are provided.

All clients shall be preauthorized for service by the Behavioral Health & Recovery Services (BHRS) Division's Access Call Center.

1. Mental Health Services shall be provided by licensed, waivered or registered mental health staff and shall include the following:

a. Assessment Services, Face-to-Face – CPT Code 90791

Assessment services include clinical analysis of history and current status of client's mental, emotional or behavioral condition.

b. Treatment Services, Face-to-Face (non-MD)

i. Individual Therapy - CPT Code 90832, 90834, 90837
Individual therapy is therapeutic intervention consistent with client goals that focus primarily on symptom reduction as a means to improve functional impairments. Individual therapy is delivered to an individual but may include family or significant support persons when the individual is present, but the focus of work is on the client and not the family system.

ii. Family Therapy - CPT Code 90846, 90847
Family therapy is contact with the client and one or more family members and /or significant support persons. Services shall focus on the care and management of the client's mental health conditions within the family system.

iii. Group Therapy - CPT Code 90853
Group therapy is therapeutic intervention for more than one client that focuses primarily on symptom reduction as a means to improve functional impairments. It may include group family therapy when families of two or more clients are present, and the client is not present.

iv. Clinical Consultation – CPT Code 99442
Clinical Consultation is the deliberation of two or more mental health professionals, or between a mental health professional and other support persons, with respect to the diagnosis or treatment regarding a client.

c. Psychological Testing Services, Face-to-Face: if applicable

A contractor who accepts a referral for outpatient psychological or neuropsychological testing shall begin such testing within 5 working days of the referral. The MHP requires of the contractor to submit a comprehensive written summary of test results. This summary shall be sent to MHP in a timely manner, if not sent earlier, it must accompany the claim or payment will be denied. Summary goes to:

Access Call Center
Attn: T. J. Fan, PhD.
Fax: (650) 596-8065

d. Medication Support Services, Face-to-Face: If applicable

Medication support services shall be provided if medically necessary by a licensed physician (psychiatrist). These services include the following:

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

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

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

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

Medication education (including discussing risks, benefits, and alternatives with the significant support persons of client).

D. San Mateo Contractors' Association Grant Funding

1. The parties acknowledge and agree that Contractor is the fiscal agent for an association of community-based organizations known as the San Mateo Contractors' Association (the "Association"). By definition Association members individually contract with BHRS and are current on their respective Association membership dues

2. Contractor shall provide accountability and oversight of a program (the "Program") the goal of which is for each funding recipient (as defined in Paragraph II.B.3.a.) to be able to:

a. Improve capacity to provide integrated models for addressing trauma and co-occurring disorders;

b. Improve its capacity to incorporate evidence-based practices into day-to-day resources;

c. Improve its cultural competency; and

d. Improve its capabilities to collaborate, partner and share resources and information with other Association Members.

3. Contractor shall provide accountability and collect data on each funding recipient's (as defined in Paragraph II.B.3.a.) progress toward the following outcome:

Objective: A minimum of seventy-five percent (75%) of Funding Recipients' staff who provide direct services will participate in training that develops new skills in the areas of trauma, co-occurring disorders and/or cultural awareness.

Measurement: Participation in activities listed above will be recorded and reported to Contractor by Funding Recipients.

Data collection to be completed by Contractor and reported to BHRS by May 31, 2020, and May 31, 2021.

4. Program Participation Eligibility and Application

a. Association Members whose individual contract with BHRS is or will be equal to or greater than FIFTY-THOUSAND DOLLARS ($50,000) for FY 2019-20, and FIFTY THOUSAND DOLLARS for FY 2020-21:

i. An Association Member whose individual contract with BHRS is or will be equal to or greater than FIFTY-THOUSAND DOLLARS ($50,000) for FY 2019-20 and FIFTY THOUSAND ($50,000) for FY 2020-21, and who has initiated a self-assessment of trauma, co-occurring capability, cultural awareness evaluation using the ("COMPASS™") or a similar tool and identified an action plan for improvement may apply to the Association for a grant of up to TEN THOUSAND DOLLARS ($10,000) annually to be used by such Association Member to accomplish program goals.

ii. Contractor will supply an application form which shall include a budget, stated outcomes, and a description of how such Association Member will use the funds to improve staff skills in addressing trauma, co-occurring disorders, and/or cultural awareness. Funding Recipient may use funds to:

1) Allow funding recipient's staff to participate in BHRS system transformation activities, and/or
2) Initiate internal training activities on the topic of or related to identifying and serving individuals with trauma or co-occurring disorders.
3) Initiate internal training activities on the topic of cultural awareness.

b. Association Members whose individual contract with the BHRS is or will be less than FIFTY THOUSAND DOLLARS

($50,000) for FY 2019-20 and FIFTY THOUSAND DOLLARS for FY 2020-21:

i. An Association Member whose individual contract with the BHRS is or will be less than FIFTY THOUSAND DOLLARS ($50,000) for FY 2019-20, and FIFTY THOUSAND DOLLARS ($50,000) for FY 2020-21, may apply to the Association for a grant of up to TWO THOUSAND FIVE HUNDRED DOLLARS ($2,500) annually to be used by such Association Member to accomplish program goals.

ii. Such application shall take the form of a letter which shall include a budget, stated outcomes, and a description of how such Association Member will use the funds based on the applicants assessment tool and the subsequent action plan for improvement. In addition, the description shall include how such Association Member will use the funds to:

1) Address next steps or action plan activities identified through,
2) Allow such Association Member's staff to participate in BHRS system transformation activities, and/or
3) Initiate internal training activities on the topic of or related to identification of and providing services to individuals with trauma and co-occurring disorders.

c. Determining Funding Recipients ("Funding Recipient(s)")

i. The Executive Committee of the Contractor's Association will review grant applications from Association Members and make determinations as to the funding recipients.

ii. Eligibility for additional funding for a particular funding recipient shall be contingent upon such funding recipient's successful completion of their respective goals.

iii. In order to be considered by the Executive Committee, grievances regarding grant funding decisions must be submitted in writing to the Executive Committee for review.

c. Contractor shall collect data and materials necessary to complete periodic reports and a final report on Program outcomes for the year. A final report will be prepared which identifies new or expanded needs of the funding recipients relative to the program goals. Contractor shall provide grant

funding status report to the BHRS within thirty (30) days of the end of FY 2019-20 and FY 2020-21.

E. Technology Supports for Clients

Through the Mental Health Service Act (MHSA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, BHRS has secured funding to provide technology supports (devices and data plans) for clients and family members of clients that would benefit from telehealth and/or other behavioral health services, but do not have the resources to purchase the technology they need.

BHRS selected a federally-subsidized program, T-Mobile For Government, that offers a low-cost data plan (internet service) along with free refurbished phones/tablets. Given the limited resources, this benefit should be prioritized for clients and families most in need and who are unable to take advantage of other low-cost and/or income-based technology supports.

1. Services

a. Through CARES Act funding, BHRS purchased fifteen (15) tablets for Contractor to support client participation in services. T-Mobile will mail the tablets directly to Contractor; Contractor will distribute the tablets in accordance with the guidance set forth in this agreement.

b. For MHSA One-Time funding, Contractor will contact the T-Mobile For Government representative directly to procure additional devices and data plans needed for clients. MHSA One-Time funding can be used to purchase phones and tablets; and/or purchase headphones, screen protectors, device covers, and/or other device accessories as needed to support client participation in services. See Attachment T – Frequently Asked Questions (FAQ) for contact information and other information about the T-Mobile For Government program.

c. Contractor will develop a screening or process to allocate the devices to clients and families most in need and who are unable to take advantage of other low-cost and/or income-based technology services.

d. Contractor will develop a user agreement for clients to support safety and accountability while using the devices. See Attachment U – Sample Device User Agreement and Waiver.

2. Reporting Activities

a. As a condition of accepting the CARES Act funded tablets, Contractor is required to submit monthly Tracking Logs, see Attachment V - Technology Supports – Monthly Reporting Form. Contractor shall report the following:
   i. Client(s) name receiving tablet for participation in services.
   ii. Number of devices used to support client services on-site (for example, a shared tablet at residential facility to facilitate group sessions, field services, etc.); including the following information:
      (1) location/site;
      (2) service provided using the device(s); and
      (3) number of clients served.

b. For MHSA One-Time funding, Contractor will submit the monthly Tracking Logs, see Attachment V - Technology Supports – Monthly Reporting Form along with invoices for reimbursement:
   i. Total number of phones and total number of tablets ordered.
   ii. Detail other device accessories purchased to support client participation in services.
   iii. Client(s) name and device (phone/tablet) and/or accessories received.
   iv. Number of devices used to support client services on-site (for example, a shared tablet at residential facility or lobby, to facilitate group sessions, field services, etc.); including the following information:
      (1) location/site;
      (2) service provided using the device(s); and
      (3) number of clients served.

II. 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 5%, and 3) first

appointment will be within 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 15 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.

Substance Use provider services shall be in compliance with the Alcohol and Other Drug Services Provider Handbook which is located online at http://www.smchealth.org/bhrs/aod/handbook.

Managed Care providers shall document services in accordance with the BHRS Managed Care Provider Manual: located online at http://www.smchealth.org/sites/default/files/docs/BHRS/Providers/ManagedCareProviderManual.pdf. Managed Care Providers will utilize documentation forms located at http://www.smchealth.org/bhrs/contracts.

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

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 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:

a. 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

b. Obtain a waiver from Community Care Licensing allowing the employee to provide services to individuals with whom they have contact as 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 1st 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 ode@smcgov.org to plan for appropriate technical assistance.

C. 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.

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. Mental Health Services (Authorized by the Mental Health Plan) July 1, 2019 – September 30, 2020

1. Policies and Procedures

Contractor will maintain compliance with policies and procedures, and other requirements contained within the Managed Care Provider Manual, including any additions or revisions. The Managed Care Provider Manual is located at http://www.smchealth.org/bhrs/contracts and is incorporated in this agreement by reference herein.

2. Professional Standards

Contractor's professional shall perform their duties under this Agreement in accordance with the rules of ethics of the medical profession. Contractor's staff shall also perform their duties under this Agreement in accordance with the appropriate standard of care for their medical profession and specialty.

3. Qualifications

a. Contractor's professional staff shall at all times keep and maintain a valid license to engage in the practice of medicine in the State of California.

b. Contractor shall be certified by the appropriate State recognized Board in California (or eligible for certification by such Board by virtue of having successfully completed all educational and residency requirements required to sit for the Board examinations).

4. Requirement of Contractor to Notify County of any Detrimental Professional Information or Violation of County Rules or Policies

Contractor shall notify County upon the occurrence of any and/or all of the following:

a. Contractor's license to practice medicine in any jurisdiction is suspended, revoked, or otherwise restricted;

b. A complaint or report concerning Contractor's competence or conduct is made to any state medical or professional licensing agency;

c. Contractor's participation as a Medicare or Medi-Cal provider is under investigation or has been terminated;

d. There is a material change in any of the information the Contractor has provided to County concerning Contractor's professional qualification or credentials;

e. Contractor must also notify the County within thirty (30) days of:
   i. any breach of this Agreement;
   ii. any material violation of County's rules or regulations by the Contractor himself/herself; or
   iii. if the Contractor is subject to or participates in any form of activity which would be characterized as discrimination or harassment.

5. Automatic Termination
This Agreement shall be immediately terminated as follows:

a. Upon Contractor's loss, restriction or suspension of his or her professional license to practice medicine in the State of California;

b. Upon Contractor's suspension or exclusion from either the Medicare or Medi-Cal Programs;

c. If the Contractor violates the State Medical Practice Act;

d. If the Contractor's professional practice imminently jeopardizes the safety of clients;

e. If Contractor violates ethical and professional codes of conduct of the workplace as specified under state and federal law;

f. Contractor has a guardian or trustee of its person or estate appointed by a court of competent jurisdiction;

g. Contractor becomes disabled so as to be unable to perform the duties required by this Agreement;

h. Contractor fails to maintain professional liability insurance required by this Agreement.

6. Standard Appointment Scheduling

Contractor shall return phone calls to an authorized client within **one (1) business day**. Contractor shall schedule an initial visit with an authorized client within **five (5) business days of the client's request for an appointment**.

Contractor must notify the Access Call Center at 1-800-686-0101 to be placed on the Provider List as not accepting new client referrals when temporarily unable to meet this standard due to vacations, filled schedules, etc. It is the provider's responsibility to notify Access Call Center when provider resumes the ability to accept new client referrals.

7. Advance Directives

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

8. Beneficiary Brochure and Provider List

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

9. Certification

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

III. GOALS AND OBJECTIVES

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

A. Crisis Residential Treatment Services

Goal: To increase or maintain consumers in the community and decrease referrals to psychiatric emergency services (PES).

Objective: No more than twenty percent (20%) of the consumers receiving Crisis Residential Treatment Services shall be referred to psychiatric emergency services (PES).

Data collection to be completed by the County in cooperation with Contractor.

B. Transitional Residential Treatment Services

Goal: To increase or maintain consumers remaining in a community-based setting.

Objective: At least seventy percent (70%) of consumers discharged after completion of six (6) months or more of treatment in Transitional Residential Treatment Services program shall be discharged to more independent living.

Data collection to be completed by the County in cooperation with Contractor.

C. Case Management Programs

REACH

1. Intensive Case Management

Goal: To increase or maintain consumers in the community and out of the hospital.

Objective: No more than fifteen percent (15%) of the consumers in each of the programs listed above in this Paragraph VI. C. shall be hospitalized.

Data collection to be completed by the County.

2. Homeless

Goal: To increase or maintain consumers in community housing and not becoming homeless.

Objective: No more than five percent (5%) of consumers in each of the programs listed above in this Paragraph VI.C. become homeless.

Data collection to be completed by Contractor.

3. Enhanced Supported Education Services for Transitional Age Youth (TAY)

Goal: To increase the educational outcomes of TAY with serious mental illness.

Objective: At least eighty percent (80%) of TAY enrolled in peer counseling or skills development courses will successfully complete those classes.

Data collection to be completed by Contractor.

4. Employment

Goal: To increase or maintain consumers working in paid or unpaid positions, or actively seeking employment.

Objective: Ten percent (10%) of consumers in each of the programs listed above in this Paragraph VI.C. and thirty percent (30%) of Yail consumers will be working in paid or unpaid positions, or actively seeking employment.

Data collection to be completed by Contractor.

5. Supportive Housing Program

Goal: To provide stable housing for consumers served in treatment programs administered under this Agreement.

Objective: At least eighty percent (80%) of property management consumers will maintain their residences for at least twelve (12) months.

Data collection to be completed by Contractor

6. Incarcerations

Goal: To increase or maintain consumers in the community and not being incarcerated.

Objective: No more than five percent (5%) of consumers in each of the programs listed above in this Paragraph VI.C. shall be incarcerated.

Data collection to be completed by Contractor

D. New Ventures Case Management

1. Homeless

Goal: To increase or maintain consumers in community housing and not becoming homeless.

Objective: No more than five percent (5%) of consumers in each of the programs listed above in this Paragraph VI.C. become homeless.

Data collection to be completed by Contractor

2. Enhanced Supported Education Services for Transitional Age Youth (TAY)

Goal: To increase the educational outcomes of TAY with serious mental illness.

Objective: At least eighty percent (80%) of TAY enrolled in peer counseling or skills development courses will successfully complete those classes.

Data collection to be completed by Contractor

3. Employment

Goal: To increase or maintain consumers working in paid or unpaid positions, or actively seeking employment.

Objective: Thirty percent (30%) of New Ventures and YAIL consumers and ten percent (10%) of REACH consumers will have an objective on their treatment plans focused on vocational and/or educational development.

Data collection to be completed by Contractor.

4. Supportive Housing Program

Goal: To provide stable housing for consumers served in treatment programs administered under this Agreement.

Objective: At least eighty percent (80%) of property management consumers will maintain their residences for at least twelve (12) months.

Data collection to be completed by Contractor.

5. Incarcerations

Goal: To increase or maintain consumers in the community and not being incarcerated.

Objective: No more than five percent (5%) of consumers in each of the programs listed above in this Paragraph VI.C. shall be incarcerated.

Data collection to be completed by Contractor.

E. Young Adult Independent Living Program

1. Homeless

Goal: To increase or maintain consumers in the community and not becoming homeless.

Objective: No more than five percent (5%) of consumers in each of the programs listed above in this Paragraph VI.C. become homeless.

Data collection to be completed by Contractor.

2. Enhanced Supported Education Services for Transitional Age Youth (TAY)

Goal: To increase the educational outcomes of TAY with serious mental illness.

Objective: At least eighty percent (80%) of TAY enrolled in peer counseling or skills development courses will successfully complete those classes.

Data collection to be completed by Contractor.

3. Employment

Goal: To maintain or increase the number of Yail consumers working in paid or unpaid positions, or actively seeking employment.

Objective: At least thirty percent (30%) of Yail consumers will be working in paid or unpaid positions, or actively seeking employment.

Data collection to be completed by Contractor.

D. Satisfaction

Goal: To enhance consumers' satisfaction with the services provided.

Objective: At least ninety percent (90%) of customer survey respondents will rate services as good or better.

Objective: At least ninety percent (90%) of customer survey respondents will rate access to mental health services as good or better.

*** END OF EXHIBIT A.1.1 ***

EXHIBIT B.1.1 – MENTAL HEALTH SERVICES PAYMENTS AND RATES
CAMINAR, INC.
FY 2019 – 2021

In consideration of the services provided by Contractor in Exhibit A.1.1, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

In full consideration of the services provided by Contractor under this Agreement and subject to the provisions of Paragraph 3 of this Agreement, County shall pay Contractor in the manner described below:

A. Maximum Obligation

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

In any event, the maximum amount county shall be obligated to pay for all services rendered under this contract shall not exceed TWENTY MILLION FIVE HUNDRED SEVENTY-THREE THOUSAND FIVE HUNDRED FIFTY-FIVE DOLLARS ($20,573,555).

B. FY 2019 – 2020

1. Subject to the availability of funding for services as described in Section I of Exhibit A.1.1, Contractor shall receive a maximum of EIGHT MILLION THIRTY THOUSAND SEVEN HUNDRED NINETY-TWO DOLLARS ($8,030,792) for Housing, Housing-Related Mental Health Services, Case Management and Rehabilitation Services. This amount shall include the following:

a. Maximum Amount By Service Component

County shall not pay or be obligated to pay more than the amounts listed below for each component of service described in Paragraph I of Exhibit A.1.1:

Crisis Residential Treatment Services	1,561,891
Transportation – Crisis Residential	20,864
Transitional Residential Treatment Services	1,517,023
Transportation – Transitional Residential	27,194
REACH	1,300,281

REACH North/Central Case Management	81,952
Med Clinic	869,432
New Ventures	1,248,569
WRAP	123,033
Supported Education	120,114
Supported Employment	123,311
Transition Age Youth (TAY)	190,706
Young Adult Independent Living (YAIL)	435,800
Supported Housing – Existing Program	243,285
Supported Housing – Expansion	167,337 *
TOTAL	8,030,792

* To be paid on a fee-for-service basis. See I.B.3. below.

b. Rate of Payment

Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the full cost of providing services described in Section I of Exhibit A.1.1. Unless otherwise authorized by the Chief of San Mateo County Health or designee, the monthly payment by County to Contractor for the services described in Paragraph I.B. of this Exhibit B.1.1 shall be one-twelfth ($1/12^{th}$) of the total obligation for those services or SIX HUNDRED FIFTY-FIVE THOUSAND TWO HUNDRED EIGHTY-SEVEN DOLLARS AND EIGHTY-EIGHT CENTS ($655,287.88).

c. Supportive Housing - Expansion

i. The total Supported Housing-Expansion costs shall not exceed ONE HUNDRED SIXTY-SEVEN THOUSAND THREE HUNDRED THIRTY-SEVEN DOLLARS ($167,337) and is included in I.B.1. above.

ii. This will be paid based upon actual costs upon receipt of invoice from Contractor. Payment for client specific housing costs (i.e rent, security deposit, moving costs) will be made upon receipt of back-up documentation submitted with monthly invoice detailing the list of clients and the specific direct housing expenses paid by Contractor for each client. The invoice will also itemize personnel, operations and administrative costs. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

2. Mental Health Services (Authorized by the Mental Health Plan)

For the term July 1, 2019 through June 30, 2020, the maximum amount County shall be obligated to pay for mental health services under the MHP rendered under Exhibit A.1.1 of this Agreement shall not exceed SEVENTY-FIVE THOUSAND DOLLARS ($75,000).

County rates for reimbursement are based on the Centers for Medicaid and Medicare Services (CMS) rate schedule and are subject to change. The CMS rate schedule is located at: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx and is incorporated into this agreement by reference herein. County shall not pay or be obligated to pay more than the amounts for each component of service required under this agreement listed on the CMS rate schedule.

a. Specialty rates

Specialty rates are for services/rates that are not covered by MediCal that the County has agreed to cover. Specialty rates included in the Agreement are:

i. Collateral Services
CPT Code 90887 - $59.00 flat rate
As defined in Exhibit A.I.B.2.d.

ii. Clinical Consultation
CPT Code 99442 - $12.00 flat rate
As defined in Exhibit A.I.B.2.e.

iii. No Show
Code N0000 - $20 flat rate
A No Show is defined as: failure of client to appear for or cancel an appointment within 24 hours of the scheduled time, documented in chart at time of appointment, verifiable in retrospective audit. No Show limit is 2 per client within the first authorization period.

b. Beneficiaries

Contractor shall be compensated for services provided to the beneficiaries listed below when the Mental Health Plan (MHP) authorizes such services.

i. San Mateo County Medi-Cal beneficiaries, who are Medi-Cal eligible at the time of referral and authorization;

ii. Clients who are covered by the Healthy Kids programs, a county insurance program for low-income children;

iii. Client caregivers who are covered by HealthWorx, a state insurance program for direct in-home supportive services workers;

iv. Clients that are covered by the Health Plan of San Mateo Care Advantage/Cal MediConnect program for Medicare beneficiaries; and

v. Clients known to be uninsured for whom the MHP has assumed responsibility.

The MHP will refer and authorize services on a case-by-case basis.

c. Claims

i. Contractor shall obtain and complete HICF 1500 claim form for outpatient services, or UB 04 claim form for inpatient services rendered to beneficiaries and authorized by MHP.

ii. Contractor shall obtain a signed Assignment of Benefits (AOB) form from any dually (insurance and Medi-Cal) insured client; claims shall not be processed without an attached AOB. County reserves the right to withhold payment until a completed AOB is submitted.

iii. Contractor shall send all claims, along with evidence of authorization, to the MHP within one hundred eighty (180) days from service date. Claims that are received 180 days or more after the date of service are considered to be late claims and will be denied by County. Send all claims to:

County of San Mateo
Behavioral Health and Recovery Services
Attn: Provider Billing
2000 Alameda De Las Pulgas, Suite 280
San Mateo, CA 94403

d. Member Liability

Unless beneficiary has other health insurance coverage under Medicare, Kaiser, Blue Cross/Blue Shield, or a known insurance carrier or health plan, Contractor shall look only to the County for compensation for services provided through this agreement and, with the exception of applicable co-payments levied from a third-party insurer, shall at no time seek compensation from beneficiary. County is not responsible for co-payments levied by third party insurers and shall not accept submission of claims for co-payments.

3. San Mateo Contractors' Association Grant Funding

Subject to the availability of State funding for services as described in Section II of Exhibit A.1.1, Contractor shall receive a maximum of ONE HUNDRED EIGHT THOUSAND SIX HUNDRED DOLLARS ($108,600) for the San Mateo Contractors' Association grant funding and associated administrative costs.

a. This amount shall include the following:

i. Contractor shall be paid half of the maximum or FIFTY-FOUR THOUSAND THREE HUNDRED DOLLARS ($54,300) in July, and the remaining half of the maximum or FIFTY-FOUR THOUSAND THREE HUNDRED DOLLARS ($54,300) in January.

ii. The maximum amount to be distributed among MHSA sub-contractors shall be ONE HUNDRED THOUSAND SIX HUNDRED SEVENTY-FIVE DOLLARS ($100,675).

iii. The maximum amount County shall pay Contractor for consultant and administrative costs shall not to exceed SEVEN THOUSAND NINE HUNDRED TWENTY-FIVE DOLLARS ($7,925).

b. At any point during the Agreement term, Contractor shall comply with all reasonable requests by County to provide a report accounting for the Grant Funds distributed by the County to the Contractor to-date.

C. FY 2020 – 2021

1. Subject to the availability of funding for services as described in Section I of Exhibit A.1.1, Contractor shall receive a maximum of EIGHT MILLION THREE HUNDRED FIFTY-TWO THOUSAND

TWENTY-THREE DOLLARS ($8,352,023) for Housing, Housing-Related Mental Health Services, Case Management and Rehabilitation Services. This amount shall include the following:

a. Maximum Amount By Service Component

County shall not pay or be obligated to pay more than the amounts listed below for each component of service described in Paragraph I of Exhibit A.1.1:

Crisis Residential Treatment Services	1,624,366
Transportation – Crisis Residential	21,699
Transitional Residential Treatment Services	1,577,704
Transportation – Transitional Residential	28,282
REACH	1,352,292
REACH North/Central Case Management	85,230
Med Clinic	904,209
New Ventures	1,298,513
WRAP	127,954
Supported Education	124,918
Supported Employment	128,243
Transition Age Youth (TAY)	198,334
Young Adult Independent Living (YAIL)	453,232
Supported Housing – Existing Program	253,017
Supported Housing – Expansion	174,031 *
TOTAL	8,352,023

* To be paid on a fee-for-service basis. See I.B.3. below.

b. Rate of Payment

Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the full cost of providing services described in Section I of Exhibit A.1.1. Unless otherwise authorized by the Chief of San Mateo County Health or designee, the monthly payment by County to Contractor for the services described in Paragraph I.B. of this Exhibit B.1.1 shall be one-twelfth (1/12th) of the total obligation for those services or SIX HUNDRED EIGHTY-ONE THOUSAND FOUR HUNDRED NINETY-NINE DOLLARS AND FORTY CENTS ($681,499.40).

c. Supportive Housing - Expansion

i. The total Supported Housing-Expansion costs shall not exceed ONE HUNDRED SEVENTY-FOUR

THOUSAND THIRTY-ONE DOLLARS ($174,031) and is included in I.B.1. above.

ii. This will be paid based upon actual costs upon receipt of invoice from Contractor. Payment for client specific housing costs (i.e rent, security deposit, moving costs) will be made upon receipt of back-up documentation submitted with monthly invoice detailing the list of clients and the specific direct housing expenses paid by Contractor for each client. The invoice will also itemize personnel, operations and administrative costs. Contractor shall be responsible for collecting tenant payments to cover portions of the program costs.

2. Mental Health Services (Authorized by the Mental Health Plan)

For the term July 1, 2020 through September 30, 2020, the maximum amount County shall be obligated to pay for mental health services under the MHP rendered under Exhibit A.1.1 of this Agreement shall not exceed SEVENTY-FIVE THOUSAND DOLLARS ($75,000).

County rates for reimbursement are based on the Centers for Medicaid and Medicare Services (CMS) rate schedule and are subject to change. The CMS rate schedule is located at: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx and is incorporated into this agreernent by reference herein. County shall not pay or be obligated to pay more than the amounts for each component of service required under this agreement listed on the CMS rate schedule.

a. Specialty rates

Specialty rates are for services/rates that are not covered by MediCal that the County has agreed to cover. Specialty rates included in the Agreement are:

i. Collateral Services
CPT Code 90887 - $59.00 flat rate
As defined in Exhibit A.I.B.2.d.

ii. Clinical Consultation
CPT Code 99442 - $12.00 flat rate
As defined in Exhibit A.I.B.2.e.

iii. No Show
Code N0000 - $20 flat rate

A No Show is defined as: failure of client to appear for or cancel an appointment within 24 hours of the scheduled time, documented in chart at time of appointment, verifiable in retrospective audit. No Show limit is 2 per client within the first authorization period.

b. Beneficiaries

Contractor shall be compensated for services provided to the beneficiaries listed below when the Mental Health Plan (MHP) authorizes such services.

i. San Mateo County Medi-Cal beneficiaries, who are Medi-Cal eligible at the time of referral and authorization;

ii. Clients who are covered by the Healthy Kids programs, a county insurance program for low-income children;

iii. Client caregivers who are covered by HealthWorx, a state insurance program for direct in-home supportive services workers;

iv. Clients that are covered by the Health Plan of San Mateo Care Advantage/Cal MediConnect program for Medicare beneficiaries; and

v. Clients known to be uninsured for whom the MHP has assumed responsibility.

The MHP will refer and authorize services on a case-by-case basis.

c. Claims

i. Contractor shall obtain and complete HICF 1500 claim form for outpatient services, or UB 04 claim form for inpatient services rendered to beneficiaries and authorized by MHP.

ii. Contractor shall obtain a signed Assignment of Benefits (AOB) form from any dually (insurance and Medi-Cal) insured client; claims shall not be processed without an attached AOB. County reserves the right to withhold payment until a completed AOB is submitted.

iii. Contractor shall send all claims, along with evidence of authorization, to the MHP within one hundred eighty (180) days from service date. Claims that are received 180 days or more after the date of service are considered to be late claims and will be denied by County. Send all claims to:

County of San Mateo
Behavioral Health and Recovery Services
Attn: Provider Billing
2000 Alameda De Las Pulgas, Suite 280
San Mateo, CA 94403

d. Member Liability

Unless beneficiary has other health insurance coverage under Medicare, Kaiser, Blue Cross/Blue Shield, or a known insurance carrier or health plan, Contractor shall look only to the County for compensation for services provided through this agreement and, with the exception of applicable co-payments levied from a third-party insurer, shall at no time seek compensation from beneficiary. County is not responsible for co-payments levied by third party insurers and shall not accept submission of claims for co-payments.

3. San Mateo Contractors' Association Grant Funding

Subject to the availability of State funding for services as described in Section II of Exhibit A.1.1, Contractor shall receive a maximum of ONE HUNDRED EIGHT THOUSAND SIX HUNDRED DOLLARS ($108,600) for the San Mateo Contractors' Association grant funding and associated administrative costs.

a. This amount shall include the following:

i. Contractor shall be paid half of the maximum or FIFTY-FOUR THOUSAND THREE HUNDRED DOLLARS ($54,300) in July, and the remaining half of the maximum or FIFTY-FOUR THOUSAND THREE HUNDRED DOLLARS ($54,300) in January.

ii. The maximum amount to be distributed among MHSA sub-contractors shall be ONE HUNDRED THOUSAND SIX HUNDRED SEVENTY-FIVE DOLLARS ($100,675).

iii. The maximum amount County shall pay Contractor for consultant and administrative costs shall not to exceed SEVEN THOUSAND NINE HUNDRED TWENTY-FIVE DOLLARS ($7,925).

b. At any point during the Agreement term, Contractor shall comply with all reasonable requests by County to provide a report accounting for the Grant Funds distributed by the County to the Contractor to-date.

4. Technology Supports for Clients

Contractor shall be paid a maximum obligation of FORTY-FOUR THOUSAND THREE HUNDRED SEVENTY DOLLARS ($44,370) for Technology Supports for Clients as described in Exhibit A.1.1 Section E. of this Agreement.

1. *Contractor shall submit the corresponding Attachment V Reporting Form for the technology support of tablets, funded by the CARES Act.* Contractor's reporting shall include monthly tracking logs as described in Exhibit A.1.1 – Reporting Activities.

2. Contractor shall be paid a total of FORTY-FOUR THOUSAND THREE HUNDRED SEVENTY DOLLARS ($44,370), MHSA One-Time funding for technology supports for clients (phones, tablets, and/or device accessories). Contractor shall submit the corresponding Attachment V Reporting Form. Contractor's reporting shall include monthly tracking logs as described in Exhibit A.1.1 – Reporting Activities, along with their monthly invoice for reimbursement .

D. Contractor's annual FY 2019-20, and FY 2020-21 budgets are attached and incorporated into this Agreement as Exhibit C.

E. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.

F. Modifications to the allocations in Paragraph A of this Exhibit B.1.1 may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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).

L. At any point during the Agreement term, Contractor shall comply with all reasonable requests by County to provide a report accounting for the Grant Funds distributed by the County to the Contractor to-date.

M. 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
Attn: Contracts Unit
2000 Alameda de las Pulgas, Suite 280
San Mateo, CA 94403

N. MHP Claims

1. Contractor shall obtain and complete Health Insurance Claim Form (HICF) 1500 claim form for outpatient services, or Uniform Billing (UB) 04 claim form for inpatient services rendered to beneficiaries and authorized by the MHP.

2. Contractor shall obtain a signed Assignment of Benefits (AOB) form from any dually (insurance and Medi-Cal) insured client; claims shall not be processed without an attached AOB. County reserves the right to withhold payment until a completed AOB is submitted.

3. Contractor shall send all claims, along with evidence of authorization, to the MHP within one hundred eighty (180) days from service date. Payment by County to Contractor shall be monthly. Claims that are received one hundred eighty (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. Send all claims to:

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

O. MHP Member Liability

Unless beneficiary has other health insurance coverage under Medicare, Kaiser, Blue Cross/Blue Shield, or a known insurance carrier or health plan, Contractor shall look only to the County for compensation for services provided through this agreement and, with the exception of applicable co-payments levied from a third-party insurer, shall at no time seek compensation from beneficiary. County is not responsible for co-payments levied by third party insurers and shall not accept submission of claims for co-payments.

P. 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.

Q. 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.

R. County May Withhold Payment

Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment 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 BHRS Quality Improvement Manager. Contractor shall meet quarterly with County contract monitor, as designated by the BHRS Deputy Director, Adult and Older Adults, to review documentation and billing reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies.

S. 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.

T. Cost Report

1. Contractor shall submit to County a year-end cost report no later than ninety (90) days after the end of the fiscal year. This report shall be in accordance with the principles and format outlined in the Cost Reporting/Data Collection (CR/DC) Manual. 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 exceed 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 "rollover" may be retained by Contractor and expended the following year, provided that these funds are expended for mental health services approved by County and are retained in accordance with Paragraph Y of this Exhibit B.1.1.

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 U of this Exhibit B.1.1. 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 U of this Exhibit B.1.1. 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.

W. Claims Certification and Program Integrity

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

2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A.1.1 of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

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

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

Executed at _____ California, on _____20___

Signed _____ Title _____

Agency _____ "

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

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

   b. The beneficiary was eligible to receive services described in Exhibit A.1.1 of this Agreement at the time the services were provided to the beneficiary.

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

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

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

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

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

4. Except as provided in Paragraph II.A.4. of Exhibit A.1.1 relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the

services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

X. Unspent Funds

Contractor may rollover unspent funding from the County according to the following procedures.

1. Contractor shall submit a projected calculation of any savings no later than ninety (90) days before end of the fiscal year. The projected calculation will be a separate report from the year-end cost report. With the projected calculation Contractor shall return the amount of the savings.

2. At the time of the submission of the projected 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.

3. Contractor shall submit an accounting report of the rollover savings. This report shall include copies of the detailed expenses. The report is due ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

4. 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.

5. 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.

*** END OF EXHIBIT B.1.1 ***

EXHIBIT A.2.1 – ALCOHOL AND OTHER DRUG SERVICES
CAMINAR, INC.
FY 2019 – 2021

Behavioral Health and Recovery Services (BHRS) provides a continuum of comprehensive services to meet the complex needs of our clients and is designed to promote healthy behavior and lifestyles (a primary driver of positive health outcomes). A full range of high quality services is necessary to meet the various needs of the diverse population residing in San Mateo County (SMC). As financing, program structure and redesign changes occur, the services within this agreement may fluctuate, be further clarified, or discontinued.

In consideration of the payments set forth in Exhibit B.2.1, Contractor shall provide the following services:

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

In providing its services and operations, Contractor shall maintain compliance with requirements listed in the Alcohol and Other Drug (AOD) Policy and Procedure Manual including additions and revisions, incorporated by reference herein. As referenced in the Department of Health Care Services (DHCS) Intergovernmental Agreement for substance use disorder (SUD) services, General Definitions and Definitions specific to Drug Medi-Cal may be found in the AOD Policy and Procedure Manual located at http://smchealth.org/bhrs/aod/handbook. Documentation standards and requirements for all services may also be found in the AOD Policy and Procedure Manual located at http://smchealth.org/bhrs/aod/handbook. Reimbursement is contingent upon client eligibility, compliance with referral and authorization process and procedures, and documentation requirements as outlined in the AOD Policy and Procedure Manual located at: http://smchealth.org/bhrs/aod/policy.

A. Drug Medi-Cal Organized Delivery System SUD Treatment Services

Contractor shall provide treatment services described herein as part of the SMC Drug Medi-Cal Organized Delivery System (DMC-ODS). Contractor shall work with other ODS providers to ensure a seamless service delivery system to clients needing levels of care not provided by the Contractor. The description of all levels of care and Evidence-based Practices (EBPs) provided by SMC DMC-ODS are contained in the AOD Policy and Procedure Manual.

All program staff providing services to San Mateo County residents shall be certified or registered as defined in Title 9, CCR, Division 4, Chapter 8. SUD programs and facilities shall be licensed and/or certified by the DHCS Licensing and Certification Division. Contractors not in compliance with these requirements shall be subject to corrective action, up to and including fees, withheld payments, or termination of this Agreement.

Services will include the following:

1. Outpatient Services – ASAM 1.0

   a. Outpatient services shall be up to nine (9) hours a week for adults, and less than six (6) hours a week for adolescents as determined to be medically necessary by the Medical Director or LPHA.

      i. Outpatient treatment services for adolescents shall comply with Federal, State and Local regulations and with the Youth Treatment Guidelines set forth and as amended by the DHCS located at: http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf

   b. Outpatient services shall have of a minimum of two (2) group counseling sessions per month, and at least one (1) hour of individual counseling sessions per month.

   c. Outpatient services shall include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, case management, physician consultation, and discharge planning and care coordination. Avatar service codes for each outpatient service are:

Service Description	Service Code(s)
Intake	AD101ODS
Individual Counseling	AD102ODS
Group Counseling	AD103ODS
Individual Patient Education	AD104ODS
Group Patient Education	AD105ODS
Crisis Intervention	AD107ODS
Treatment Planning	AD109ODS
Discharge Planning	AD109ODS
Family Counseling	AD110ODS
Collateral Service	AD111ODS
Case Management	AD61
Physician Consultation	AD97ODS
Urinalysis Testing	AD75
Non-NTP Medication Assisted Treatment	AD601ODSMAT

   d. Services may be provided in-person, by telephone, or telehealth, in any appropriate setting in the community. Contractor shall ensure confidentiality of all services provided via telehealth and/or in the community.

e. Contractor shall ensure that all clients enrolled in outpatient services receive medically necessary, individualized and trauma-informed treatment services, based upon the client's ASAM needs assessment, DSM-V diagnosis, and individual clinical needs.

2. Intensive Outpatient Services – ASAM 2.1

a. Intensive outpatient services shall provide structured programming to clients as medically necessary for a minimum of nine (9) hours per week and a maximum of nineteen (19) hours per week for adult perinatal and non-perinatal clients. Adolescents are provided a minimum of six (6) hours and a maximum of nineteen (19) hours per week.

b. Intensive outpatient services shall have a minimum of one (1) hour of individual counseling session per week.

c. Intensive outpatient services shall include: intake, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, case management, physician consultation, and discharge planning and care coordination. Avatar service codes for each intensive outpatient service are:

Service Description	Service Code(s)
Intake	AD201ODS
Individual Counseling	AD202ODS
Group Counseling	AD203ODS
Individual Patient Education	AD204ODS
Group Patient Education	AD205ODS
Crisis Intervention	AD207ODS
Treatment Planning	AD208ODS
Discharge Planning	AD209ODS
Family Counseling	AD210ODS
Collateral Service	AD211ODS
Case Management	AD61
Physician Consultation	AD97ODS
Urinalysis Testing	AD75
Non-NTP Medication Assisted Treatment	AD601ODSMAT

d. Services may be provided in-person, by telephone, or telehealth, in any appropriate setting in the community. Contractor shall ensure confidentiality of all services provided via telehealth and/or in the community.

e. Contractor shall ensure that all clients enrolled in intensive outpatient services receive medically necessary, individualized and trauma-informed treatment services, based upon the client's ASAM needs assessment, DSM-V diagnosis, and individual clinical needs.

3. Unplanned or Early Terminations from All Levels of Care

For all unplanned or early terminations from treatment, Contractor shall notify Medi-Cal beneficiaries of Contractors intent to terminate service at least ten (10) days prior to end date or termination date, by providing the beneficiary with a Notice of Adverse Benefit Determination (NOABD). The NOABD shall clearly state the reason for early termination, and document previous attempts to communicate the possibility of discharge directly to the beneficiary and the treatment team when applicable. If the beneficiary is an imminent danger to themselves or others, or is gravely disabled, then Contractor may terminate services immediately and shall provide the beneficiary with a NOABD.

a. Contractor shall notify beneficiary's San Mateo County Case Manager immediately upon Contractor's knowledge of beneficiary's potential for early termination or AWOL, and no later than the same day the NOABD is issued.

b. Contractor shall notify the San Mateo County Case Manager via telephone and Avatar Consultation Request Form.

c. Should the beneficiary not be assigned to a San Mateo County Case Manager or should Contractor not know who the beneficiary's assigned Case Manager is, Contractor shall notify the San Mateo County RTX Team via telephone and Avatar Consultation Request Form.

d. Contractor shall consult and/or meet with the San Mateo County Case Manager and other individuals involved in the beneficiary's care prior to terminating the beneficiary from treatment and develop a mutually agreeable written plan to keep the beneficiary in treatment and not terminate from care prior to the planned discharge date.

e. If Contractor and the San Mateo County Case Manager determine the beneficiary needs a higher Level of Care or may be best served by a different provider, then Contractor shall work with the Case Manager and the receiving provider to ensure transition of care without any gaps in treatment.

f. Contractor and the San Mateo County Case Manager will make every effort to maintain the beneficiary in treatment and not terminate from care prior to the planned discharge date. If Contractor has issued the beneficiary a NOABD, they may rescind it if they are successful in maintaining the beneficiary in care.

g. The NOABD outlines the beneficiary's rights to appeal early terminations from care. San Mateo County will review beneficiary appeals and may mandate the provider to re-admit the beneficiary into treatment should the appeal be found in the beneficiary's favor.

4. Case Management

Case management services complement treatment services to address areas in the client's life that may negatively impact treatment success and overall quality of life. Case management services connect clients to outside systems of care, such as mental health services and primary care services. Case management also helps clients transition through different levels of care in the SUD treatment continuum. Case management services shall be provided and documented in accordance with the procedures outlined in the Documentation Manual.

a. Case management services are available to all clients who enter SUD treatment.

i. Case management services shall be provided face-to-face, by telephone, or telehealth and may be provided in any appropriate setting in the community. If services are provided in the community, Contractor shall maintain confidentiality requirements/guidelines and document how confidentiality was maintained.

ii. Case management services shall include, but are not limited to the following:

1) Comprehensive assessment and reassessment to determine medical necessity of continuation of case management services;

2) Monitor client's progress and transition coordination to a higher or lower level of SUD care, as medically necessary;

3) Facilitate warm hand-off transition in SUD level of care, including into Recovery Services, and coordinating with and forwarding necessary documentation to the receiving provider.

4) Develop and revise treatment or recovery services plan as medically necessary;

5) Communicate, coordinate, refer and any related activities;

6) Monitor service delivery to ensure client access to service;

7) Patient advocacy, linkages to physical and mental health care, transportation to and retention in primary care services; and

8) Coordinate care and communicate with primary care, MAT or NRT provider, community health clinic and mental health provider to ensure a coordinated approach to client's treatment, and monitoring and follow up with other agencies regarding appointments or other services received by the client.

9) Coordinate care and communicate with County and State entities (Probation, Parole, Child Welfare, Courts, Housing providers, RTX, Pathways, IMAT, Service Connect, Drug Court, DUI Court, etc.) to align objectives and priorities and to ensure the social aspects of health and well-being are coordinated with health services.

10) Advocate for the client with health/social providers, County or community partners, the Courts, and others in the best interest of the client.

11) Help client apply for, keep, or transfer (as needed) benefits such as Medi-Cal, General Assistance, SSI/SSDI, CalWORKs, or housing subsidies.

12) Link clients to community resources or services that maximize independence and support

recovery goals, including food banks or churches for groceries or meals, clothing assistance, transportation services, vocational services, and support for employment or education.

13) Case management shall be consistent with and shall not violate the confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

5. Physician Consultation

Physician Consultation Services include consultations between provider physicians and addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist provider physicians, allowing them to seek expert advice regarding the design of treatment plans for individual DMC beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence to treatment regiment, drug-drug interactions, or level of care considerations.

6. Recovery Services

Recovery Services shall be provided to clients following completion of treatment, when medically necessary. Recovery services may be provided face-to-face or by telephone with the client, in any appropriate setting in the community. Recovery services shall include:

a. Periodic outpatient counseling services in the form of individual or group counseling as needed to stabilize the client and reassess if client is in need of further care;

b. Recovery coaching, monitoring via telephone and internet;

c. Peer-to-peer services and relapse prevention;

d. Linkages to life skills, employment services, job training, and education services;

e. Linkages to childcare, parent education, child development support services, family/marriage education;

f. Linkages to self-help and support, spiritual and faith-based support; and

g. Linkages to housing assistance, transportation, case management, individual services coordination.

h. Avatar service codes for Recovery Services are:

Service Description	Service Code
Individual Counseling	AD501ODSRSI
Group Counseling	AD502ODSRSG
Case Management	AD503ODSRSCM
Recovery Monitoring	AD504ODSRSRM

7. Withdrawal Management

Contractor is encouraged to obtain withdrawal management (WM) certification. Once certified, Contractor shall provide WM services according to the ASAM Criteria, when medically necessary, in accordance with the client's individualized treatment plan. Avatar service codes for withdrawal management will be created upon Contractor certification.

Contractor shall ensure that clients receiving both residential services and WM services are monitored during the detoxification process. Withdrawal management services include the following:

a. ASAM 1.0-WM

Ambulatory withdrawal management without extended on-site monitoring. For clients in mild withdrawal who require daily or less than daily outpatient supervision.

b. ASAM 2.0-WM

Ambulatory withdrawal management with extended on-site monitoring. For clients in moderate withdrawal who require all day withdrawal management and support and supervision; at night, the client has a supportive family or living situation.

8. Community-Based Services

Contractors may provide outpatient or intensive outpatient services in any appropriate community setting based on client need.

a. All service locations shall comply with 42 CFR Part 2, and client confidentiality shall be maintained.

b. Contractor may provide services in multiple community settings. However, Contractor's staff may not be assigned a primary worksite that is not DMC certified without informing BHRS QM and BHRS AOD Administration. Contractor may be required to apply for DMC certification and SUDS licensure for that setting.

9. Telehealth

Contractor may utilize telehealth when providing treatment services only when the following criteria are met:

a. The professional determining medical necessity is located onsite, and the client receiving the services is located remotely.

b. All telehealth equipment and service locations comply with 42 CFR Part 2, and client confidentiality is maintained.

10. Additional DMC-ODS Services Required

The following services are also included in the DMC-ODS continuum of care, although they are not reimbursable by DMC. Contractor may provide the following services; however, Contractor shall refer clients to these services based upon client need, medical necessity, and client eligibility. Avatar service codes for additional DMC-ODS required services are:

Service Description	Service Code
Recovery Residences	AD96
	AD997 – when client is on a leave of absence

11. Contractor Requirements

a. Licensure/Agency

Contractor shall be licensed, registered, and DMC certified in accordance with applicable laws and regulations. Contractor shall comply with the following regulations and guidelines. In the event of a conflict between regulatory requirements, the more stringent provisions shall prevail.

i. Title 21, CFR Part 1300, et seq.,

ii. Title 42, CFR, Part 8;

iii. Drug Medi-Cal Organized Delivery System Special Terms and Conditions

iv. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1;

v. DHCS Alcohol and/or Other Drug Program Certification Standards;

vi. Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; and

vii. Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.

b. Staffing Requirements

Contractor shall employ licensed or certified/registered counselors in accordance with Title 9, CCR, Division 4, Chapter 8 to provide covered services.

i. Professional staff must be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. A Licensed Practitioner of the Healing Arts (LPHA) includes the following:

1) Physician

2) Nurse Practitioners

3) Physician Assistants

4) Registered Nurses

5) Registered Pharmacists

6) Licensed Clinical Psychologists

7) Licensed Clinical Social Worker

8) Licensed Professional Clinical Counselor

9) Licensed Marriage and Family Therapists

10) License Eligible Practitioners working under the supervision of Licensed Clinicians

ii. Non-Professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff shall be supervised by professional and/or administrative staff.

Contractor shall comply with HSC Section 11833(b)(1): Any individual who provides counseling services in a licensed or certified alcohol and other drug (AOD) program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization prior to providing counseling services.

In Fiscal Year 2019-2020, San Mateo County BHRS will establish a minimum expectation that a set percentage of Contractor's AOD counselors will be certified with a DHCC approved certifying organization. A Contractor not in compliance with the minimum expectation will be required to submit a request for a temporary exemption. The request will include justification for the exemption, and a plan with a timeline to meet the minimum expectation.

iii. Professional and Non-Professional staff shall have appropriate experience and all necessary training at the time of hiring.

iv. Registered and certified SUD counselors providing treatment services shall adhere to all certification requirements in the CCR Title 9, Division 4, Chapter 8 and HSC Section 11833 (b)(1).

v. Prior to delivery of services under this Agreement, Contractor shall employ a Medical Director enrolled with DHCS under applicable state regulations, screened as a limited categorical risk within one (1) year prior to serving as Medical Director in accordance with 42CFR455.50(a), and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

vi. All staff of Contractor shall undergo fingerprint background checks prior to hiring or service delivery, whichever comes first in accordance with CFR 455.34.

vii. Prior to the delivery of services, all treatment staff shall be trained in ASAM criteria, which consists of two e-training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care".

c. Other Requirements

Contractor shall comply with all DHCS DMC-ODS mandated reporting requirements, and is required to inform BHRS QM and BHRS Program Analyst within forty-eight (48) hours after an occurrence, of the following:

i. Leadership or staffing changes.

ii. Organizational and/or corporate structure changes (example: conversion to non-profit status).

iii. Changes in the type of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.

iv. Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).

v. Change of ownership or location.

vi. Complaints regarding the provider

12. Client Eligibility

a. Clients are eligible to receive DMC-ODS services if they: (a) are receiving San Mateo County Medi-Cal benefits or are eligible to receive San Mateo County Medi-Cal benefits; (b) are not currently institutionalized; (c) have a substance use disorder per the most current published edition of the Diagnostic and Statistical Manual (DSM-V) and meet ASAM medical necessity criteria; and (d) are a San Mateo County resident.

b. Clients may also be eligible to receive treatment and recovery services under San Mateo County's DMC-ODS network of care using non-Medi-Cal funding if they: (a) do not have health care coverage; (b) are not currently institutionalized; (c) have

a substance use disorder per the most current published edition of the Diagnostic and Statistical Manual (DSM-V) and meet ASAM medical necessity criteria; and (d) are a San Mateo County resident.

c. Contractor Responsibilities:

i. Contractor shall verify the client's residency status to ensure they are a San Mateo County resident. Homeless or transient clients shall be homeless or transient in San Mateo County. A statement of verification shall be kept in the client's file.

ii. Contractor shall verify the client's Medi-Cal eligibility status on a monthly basis. Verification of Medi-Cal eligibility shall be kept in the client's file.

d. Medical Necessity

i. Medical necessity shall be determined by the Medical Director, licensed physician, or LPHA. After establishing a DSM-V diagnosis, the diagnosing professional shall apply ASAM criteria to determine the appropriate level of care for placement.

ii. Medical necessity for adults age twenty-one (21) and over is determined by the following:

1) The individual has at least one (1) substance-related diagnosis from the DSM-V, excluding tobacco-related disorders.

2) The individual meets the ASAM Criteria definition of medical necessity to receive services.

iii. Medical necessity for youth and adults under the age of twenty-one (21) is determined by the following:

1) The individual is assessed to be at risk for developing a substance use disorder, and

2) The individual meets the ASAM Criteria definition of medical necessity for adolescent services.

iv. Medical necessity shall be re-evaluated and re-determined at each Treatment Plan update, each Level of Care change, and at least once every six (6) months for the duration of treatment services.

1) Narcotic Treatment Programs/Opioid Treatment Programs shall re-evaluate and re-determine medical necessity at least annually for the duration of treatment services.

13. Timely Access to Service

a. Contractor shall deliver the client's first appointment for outpatient or intensive outpatient services within ten (10) calendar days of the initial request.

b. Contractor shall deliver the client's first appointment for residential services within three (3) calendar days of the initial request.

i. Interim services shall be provided to injection drug using and perinatal services-eligible clients when residential services are not immediately available.

c. Contractor shall ensure that a client experiencing a medical or psychiatric emergency will be transported to the nearest hospital for treatment.

d. Contractor shall advise clients in the program of the County's twenty-four (24) hour on-call Access Call Center. Contractor shall advise clients how to receive treatment or other covered services after hours, weekends and holidays.

e. Contractor's hours of operation shall be no less than the hours of operation to non-Medi-Cal clients.

14. Coordination of Care

Contractor shall provide coordination of client care. Initial care coordination may be provided by the BHRS Residential Treatment Authorization Team (RTX), Whole Person Care (WPC) or Integrated Medication Assisted Treatment Team (IMAT). Once a client is enrolled in and connected to the SUD treatment program, care coordination will be transferred to Contractor. Care coordination responsibilities will comply with those identified in the BHRS DMC-ODS Implementation Plan.

a. Contractor shall ensure coordination and continuity of care within the standards in accordance with 42 CFR 438.208.

b. Contractor shall ensure that through the course of coordinating care, the client's privacy is protected in accordance with all Federal and State privacy laws, including but not limited to 45 CFR 160 and 164, to the extent that such provisions are applicable.

c. Contractor shall ensure that female and transgender male clients have direct access to a women's health specialist, to provide routine and preventive health care services necessary, within the network for covered care. This is in addition to the clients designated source of primary care if that source is not a women's health specialist, pursuant to 42 CFR 438.206(b)(2).

d. Contractor shall provide treatment services to clients receiving Medication Assisted Treatment. Contractor shall communicate regularly with the prescribing physician(s) of client prescribed medications unless the client refuses to consent to sign a 42 CFR part 2 compliant Release of Information for this purpose.

15. Sharing Information with Clients

Contractor shall not prohibit or restrict any licensed, registered or certified professional staff, acting within their scope of practice, from advising or advocating on behalf of the client, for whom Contractor is providing SUD treatment from any of the following:

a. The client's health status, medical care or treatment options including any alternative treatment that may be self-administered.

b. Any information the client needs in order to decide among all relevant treatment options,

c. The risks, benefits and consequences of treatment or non-treatment,

d. The clients' right to participate in decisions regarding his/her healthcare including the right to refuse treatment and to express preference regarding future treatment decisions.

16. Laboratory Requirements

Contractor shall use testing services of certified laboratories that are in good standing to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) unless exempt from CLIA or are SAMHSA certified.

B. Non-Drug MediCal Organized Delivery System Services

Contractor shall provide substance use disorder (SUD) treatment and recovery services, with structure and supervision, to further a participant's ability to improve his/her level of functioning. Any program staff providing services to San Mateo County residents shall be certified or registered as defined in Title 9, CCR, Division 4, Chapter 8. SUD programs and facilities shall be licensed and/or certified by the DHCS Licensing and Certification Division.

1. Recovery Residence

A Recovery Residence (RR) provides a safe and healthy living environment to initiate and sustain treatment and recovery from SUDs. A RR may be divided into levels of support based on the type, intensity and duration of support offered. RRs do not provide SUD services or require licensure by DHCS. All RR residents must be actively engaged in medically necessary SUD treatment or recovery services. All SUD treatment services shall be provided off-site.

a. Contractor shall cooperate with BHRS staff in the continued development of RR standards and requirements.

b. Contractor shall maintain all zoning, fire clearance, and evious licensing requirements.

c. Contractor shall employ twenty-four (24) hour staff supervision and resources necessary to provide close and consistent care of residents at the RR.

d. Services provided shall include peer-to-peer recovery support, social and recreational activities, medical and counseling services as medically necessary and appropriate on the client care plan. Services shall not include any treatment at the RR which require a DHCS SUD residential license.

e. Contractor shall have a written policy regarding the use and storage of residents prescribed, psychotropic and/or narcotic based medications. The RR shall not dispense medication but must ensure that medications are properly secured.

f. Contractor shall provide residents with copies of all policies, procedures, house rules and expectations during the interview process or at the time of admission. One policy shall address the use and possession of alcohol, marijuana, illegal substances and non-prescribed medications (excluding OTC). Contractor shall have written policies on sexual harassment and verbal abuse, weapons, client grievance and incident reporting.

g Contractor shall comply with the provision of 42 C.F.R. Part 2.

h. Residents shall be enrolled and actively participate in a DHCS certified Outpatient or Intensive Outpatient Treatment program, and services must be medically necessary.

i. Contractor shall coordinate services with the Outpatient or Intensive Outpatient treatment provider.

ii. If Contractor also has an Outpatient or Intensive Outpatient Treatment program, the resident shall not be required to attend Contractor's program as a condition of residing at the RR.

i. Contractor shall assist residents in scheduling health and legal appointments; and, if necessary, provide transportation.

j. Contractor shall provide meals to the residents three (3) times daily and provide personal sundries, towels, linens, and laundry bag, if needed.

k. Contractor shall maintain regular, ongoing progress notes pertinent to each resident's living skills and their movement towards the goals outlined in their individual care plan.

l. Contractor shall permit and cooperate with BHRS monitoring of its performance and contract compliance and shall permit BHRS to review and audit client charts and documents.

2. Urinalysis Testing

Urinalysis (UA) Testing is a therapeutic intervention when deemed medically appropriate and is used to determine appropriate levels of client care. A positive UA test result may indicate a client's current level of care is not adequate and/or that the client treatment plan should be adjusted.

Contractor shall establish procedures which protect against falsification and/or contamination of any urine sample, and must document urinalysis results in the client's file.

C. Priority Populations

Through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, BHRS is required to serve priority population clients. Contractor shall establish partnerships for the provision of referral to interim or treatment services when capacity is not available, as described in the AOD Policy and Procedure Manual. Contractor shall give priority admission to the following populations, provided they are residents of San Mateo County and do not have health care coverage:

1. Pregnant females who use drugs by injection;

2. Pregnant females who use substances;

3. Other persons who use drugs by injection; and

4. As Funding is Available – all other clients with a SUD, regardless of gender or route of use, without insurance or for whom coverage is terminated for short periods of time.

II. ADMINISTRATIVE REQUIREMENTS

In providing its services and operations, Contractor shall maintain compliance with requirements of the AOD Policy and Procedure Manual, including additions and revisions, which are incorporated by reference herein.

A. System-Wide Improvements

The County has identified issues which require a collaborative and comprehensive approach in order to enhance the system-wide effectiveness and efficiency. Contractor shall implement the following:

1. Community Service Areas

Contractor shall participate in activities to improve the partnership and service delivery within the CSA location. Contractor shall report on participation in CSA activities and accomplishments through the quarterly narrative.

2. External Quality Reviews

DHCS has contracted with an External Quality Review (EQR) organization to conduct a review of the overall quality of services,

service accessibility, and availability provided under the ODS. The EQR also requires annual Performance Improvement Projects (PIP) that improve both clinical and administrative performance of the ODS.

a. Contractor shall participate in EQR focus groups, surveys, and other performance measurement and data collection activities.

b. Contractor shall participate in all PIPs implemented by BHRS as part of the EQR process.

3. Direct Service Time

Contractor shall report the time spent providing direct services to clients. Contractors shall develop and implement a weekly direct service time target of fifty-five percent (55%) for staff who provide direct clinical, counseling, and/or treatment services to clients. Contractors may request assistance from BHRS in meeting this requirement.

a. A Contractor providing outpatient and intensive outpatient treatment services shall report the number of minutes spent providing intake, individual counseling, group counseling, individual patient education, group patient education, crisis intervention, treatment planning, case management, physician consultation, discharge services, and documentation of these services in Avatar.

b. A Contractor providing residential treatment services and enhanced services shall report the number of minutes spent providing intake, individual counseling, group counseling, individual patient education, group patient education, crisis intervention, treatment planning, case management, physician consultation, discharge services, and documentation of these services to the AOD program analyst on a quarterly basis.

B. Qualified Service Organization

As a qualified service organization, BHRS agrees to provide the following services to Contractor:

1. Centralized screening, assessment, and treatment referrals;

2. Billing supports and services;

3. Data gathering and submission in compliance with Federal, State, and local requirements;

4. Policies and procedures related to the service provision, documentation, and billing;

5. Quality Management and utilization review, including problem resolution;

6. Education, training and technical assistance as needed.

C. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that no aspect of its substance use treatment program services shall include any messaging in the responsible use, if the use is unlawful, of drugs or alcohol. This is including but not limited to: program standards, curricula, materials, and teachings. These materials and programs may include information on the health hazards of use of illegal drugs and alcohol, concepts promoting the well-being of the whole person, risk reduction, the addictive personality, development of positive self-esteem, productive decision-making skills, and other preventive concepts consistent with the "no unlawful use" of drugs and alcohol message. This does not apply to any program receiving state SAPT/NRC funding that provides education and prevention outreach to intravenous drug users with AIDS or AIDS-related conditions, or persons at risk of HIV-infection through intravenous drug use. (Health and Safety Code Sections 11999-11999.3).

D. Restriction on Distribution of Sterile Needles

Contractor shall not use any SAPT Block Grant/NRC funds made available through this agreement to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

E. AVATAR Electronic Health Record

1. Contractor shall enter client data into Avatar for services provided that includes: date of service, service type, service units and service duration.

2. Contractor shall maintain compliance with all documentation, reporting, billing and all other data requirements as required in the BHRS Documentation Manual, Title 22, DMC-ODS STCs, the DHCS AOD Program Certification Standards, CalOMS Tx Data Collection Guide, DMC Billing Manual, and the AOD Policy and Procedure Manual, including additions and revisions.

3. Contractor shall submit electronically treatment capacity and waitlist data to DHCS via DATAR. Contractor shall comply with all BHRS tracking methods for client waitlist times and capacity. This information shall be used to determine unmet treatment needs and wait times to enter treatment.

4. Contractor shall participate in Avatar trainings and monthly Avatar User Group (AUG) meetings to ensure data quality and integrity, and provide input into system improvements to enhance the system.

F. Quality Management and Compliance

1. Clinical Standards of Care and Evidenced-Based Practices

All services provided under this agreement shall be safe, effective, patient centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine.

a. In providing its services and operations, Contractor shall maintain full compliance with the San Mateo County BHRS Standards of Care, Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients, Federal Cultural and Linguistic Access Standards (CLAS) requirements. Contractor shall comply with at least two (2) of the five (5) DMC-ODS Evidenced-Based Practices. Annually, Contractor shall provide a written report on the status of compliance with, and annual staff training on, the following:

i. Standards of Care

ii. Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients

iii. At least two (2) of the DMC-ODS Evidenced-Based Practices. The DMC-ODS Evidenced-Based Practices include: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education

iv. Federal CLAS requirements

2. Complex Clients and Co-occurring Disorders

a. Contractor shall implement co-occurring capable policies, procedures, assessments, treatment planning, program content, and discharge planning. Contractor shall coordinate and collaborate with behavioral and physical health services,

and: initiate and coordinate with mental health services when appropriate, provide medication monitoring, coordinate with primary health services, and addiction and psychological assessment and consultation.

b. Contractor shall not exclude from treatment, persons who require high risk, specialized services or special health needs. Contractor shall work with the health care providers of clients with special health care needs. Contractor shall collaborate with BHRS and other service providers to meet the identified needs of such clients. Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the client's diagnosis, type of illness, or condition of the client. Contractor shall provide Medi-Cal beneficiaries with a NOABD each time Contractor denies or reduces the amount, duration, or scope of services the beneficiary is receiving.

   i. Contractor shall seek ongoing training and support for staff to stay current with best practices for serving individuals with co-occurring disorders.

   ii. A Contractor that provides SAPT Block Grant Perinatal services to pregnant and postpartum individuals shall comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women, and with the DHCS Perinatal Practice Guidelines.

   iii. Women, transgender men, and gender nonconforming Medi-Cal beneficiaries who are pregnant or up to sixty (60) days postpartum are eligible to receive DMC-ODS Perinatal services.

   iv. A Contractor that provides adolescent treatment services shall comply with the Youth Treatment Services Guidelines. Assessments and services for adolescents shall follow the ASAM Adolescent Treatment Criteria.

3. 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 ten (10) days of referral or request of service for outpatient services; twenty-four (24) hours for residential treatment; and three (3) calendar days for NRT.

BHRS QM will provide feedback if the plan submitted is missing critical components related to San Mateo County requirements. Additional feedback may be available if requested prior to the submission date.

a. Contractor shall have an established Quality Improvement (QI) plan and committee.

b. The QI committee shall include staff from all levels of the Agency and will guide the development and implementation of the annual QI plan. The QI committee shall review quarterly utilization and service quality, performance data, compliance with BHRS SOC, co-occurring and complex client capability, and client feedback.

c. Contractor shall establish and/or maintain mechanisms whereby processes and practices at the organizational level; which create inefficiencies and/or present barriers to client engagement, enrollment and retention in treatment, will be identified and addressed. An analysis of policies and practices which create barriers for complex clients shall be included.

4. Grievance Process

Contractor shall notify beneficiaries of their right to the following:

a. a state fair hearing, how to obtain a hearing and representation rules at the hearing;

b. file grievances and appeals, and the requirements and timeframes for filing;

i. Beneficiaries may file a grievance, either orally or in writing, either with DHCS, the County, or the Contractor

ii. Beneficiaries may request assistance with filing grievances and appeals

iii. If the beneficiary is grieving or appealing the termination, denial, or a change in type or frequency of

services, the beneficiary may request services be continued during the appeal or state fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.

c. give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal.

5. Referring Individuals to Psychiatrist

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

6. Medication Storage and Monitoring

For Contractors that provide or store medications: Contractor shall store and monitor medications in compliance with all pertinent state and federal standards. Policies and procedures must be in place for monitoring, 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 staff authorized to monitor 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. Over the counter medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

7. Record Retention

Paragraph 15 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.

8. 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. 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.

Substance Use provider services shall be in compliance with the Alcohol and Other Drug Services Provider Handbook which is located online at http://www.smchealth.org/bhrs/aod/handbook.

9. Audits

Behavioral Health and Recovery Services QM and/or BHRS analyst 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 DHCS 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.

Contractor shall accommodate and cooperate with unannounced chart audits, chart reviews, site visits, and grievance/complaint investigations by BHRS staff with or without advance notice. BHRS has the right to audit, evaluate, inspect any books, records, charts, contracts, computer or other electronic systems of the Contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time. Contractor shall make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, charts, contracts, computer or other electronic systems related to DMC, SAPT, or any service funded by this contract.

If deficiencies are found during an audit or utilization review of Contractor's services, Contractor shall develop a Corrective Action Plan (CAP) to include the following:

a. Address each demand for recovery of payment and/or programmatic deficiency;

b. Provide a specific description of how the deficiency will be corrected;

c. Specify the date of implementation of the corrective action; and

d. Identify who will be responsible for ongoing compliance.

BHRS will review and approve or require additional changes to the CAP. Contractor failure to submit a CAP within the required timeframe and failure to complete, fully implement, or sustain a CAP over time may result in withheld or denied payments, penalty fees, or termination of this agreement.

10. Client Rights and Satisfaction Surveys

a. Administering Satisfaction Surveys

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

ii. Contractor shall participate in Treatment Perception Survey collection processes. Treatment Perception Surveys collect client satisfaction data. Contractor may solicit additional feedback from service recipients and family members. All feedback surveys shall be incorporated into Contractor quality improvement processes and plans.

iii. Contractor shall develop and administer client and family satisfaction surveys on an annual basis for quality improvement and quality assurance purposes.

b. Client/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.

11. Beneficiary Brochure and Provider Lists

Contractor shall provide Medi-Cal beneficiaries new to BHRS with a Member Handbook at the time of their first service from Contractor. The Member Handbook may be downloaded using this link: https://www.smchealth.org/sites/main/files/file-attachments/dmc-ods_member_handbook_072018.pdf.

Contractor is 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.

12. Notice of Adverse Benefit Determination

a. Contractor shall issue Medi-Cal beneficiaries a written Notice of Adverse Benefit Determination (NOABD) each time the beneficiary's service is denied, delayed, terminated, or there is a change in the amount, scope, or duration of the treatment service from what was requested by the beneficiary. Contractor shall use the appropriate BHRS provided templates when issuing a NOABD. The NOABD shall meet the requirements of 42 CFR 438.404.

b. BHRS will conduct random reviews of Contractor to ensure compliance with NOABD requirements.

13. Certification and Licensing

a. SUD Treatment Services

i. Contractors providing SUD treatment services to San Mateo County residents shall be certified and/or licensed by DHCS Licensing and Certification Division. Contractor shall maintain all applicable certifications through San Mateo County and/or DHCS to provide any of the following reimbursable services: Substance Abuse and Treatment Services, and Drug Medi-Cal reimbursed services.

ii. Contractor shall submit a copy of any licensing complaint, deficiency findings, or corrective action report issued by a licensing agency to BHRS QM and the AOD Administrator or their designee, within two (2) business days of Contractor's receipt of any such licensing report.

iii. Should Contractor cease to offer a DMC-ODS service, Contractor will work with BHRS to ensure participating clients are successfully transferred to another DMC-ODS provider.

iv. Contractor shall provide written notification to the AOD Administrator of any changes in DMC-ODS offered services at least ninety (90) days prior to implementing the changes in services.

b. DMC-ODS SUD Treatment Services

i. If at any time, Contractor's license, registration, certification, or approval to operate a substance use disorder program or provide a DMC-ODS covered service is revoked, suspended, modified, or not renewed outside of DHCS, the Contractor shall notify DHCS Fiscal Management & Accountability Branch by e-mail at DHCSMPF@dhcs.ca.gov and the BHRS Program Analyst within two (2) business days of knowledge of such change.

ii. Contractor's certification to participate in the DMC program shall automatically terminate in the event the

Contractor or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

iii. If Contractor is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the Contractor from the DMC program, pursuant to W&I Code, Section 14043.36(a). Information about Contractor's administrative sanction status is confidential until such time as the action is either completed or resolved. The DHCS may also issue a Payment Suspension to Contractor pursuant to W&I Code, Section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. DHCS will authorize BHRS to withhold payments from the DMC Contractor during the time a Payment Suspension is in effect.

14. Licensing Reports

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

15. 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.

i. On an annual basis, Contractor shall require all staff accessing client PHI or PI to sign a confidentiality statement that includes, as a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies.

c. Contractor shall install and actively use comprehensive antivirus software on all workstations, laptops and other systems that process and/or store PHI or PI. The antivirus software solution must have automatic updates scheduled at least daily.

d. All workstations, laptops and other systems that process and/or store PHI or PI shall have critical security patches applied, with system reboot if necessary. Contractor shall document the patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release. Applications and systems that cannot be patched within this timeframe due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Applications and systems that cannot be patched must have compensatory controls implemented to minimize risk, where possible.

e. 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:

i. 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;

ii. 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

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

f. 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.

16. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to BHRS Quality Management (via fax # 650-525-1762) and the BHRS analyst (via fax # 650-802-6440) when there are unusual events including but not limited to: an accident, medication error, violence or significant injury requiring medical treatment of client, staff or member of the community, death of a client, police activity, 9-1-1 call, suicide attempt, or threat to the health or safety of client, staff or member of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

Incident reports are confidential however discussion may occur with 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.

a. Contractor shall submit the written Critical Incident report via fax on the same day the incident occurred, or within twenty-four (24) hours.

b. Contractor shall not file or reference a Critical Incident report in the client's chart. However, Contractor shall document the circumstances of the event and services provided.

c. Contractor shall not collect and submit Critical Incident reports in batches.

d. Contractor shall not permit hard copies or electronic copies of the Critical Incident report to be kept by the person reporting the incident. Internal copies may only be maintained by the Contractor's compliance officer/quality management as part of quality oversight. These shall be stored in a secure location without general access. All other copies shall then be shredded or deleted.

e. Contractor shall also comply with DHCS Licensing and Certification Branch Unusual Incident reporting guidelines. The Contractor shall make a telephonic report to the DHCS Complaints and Counselor Certification Division within one (1) working day for any of the following events: client deaths from any cause, any client injury requiring medical treatment, all cases of communicable disease reportable under HSC Section 3125 or California Administrative Code Title 17 Sections 2500, 2502, or 2503, poisonings, natural disasters, and fires or explosions that occur on the premises. The telephonic report shall be followed by a written report to DHCS within seven (7) days of the event using form DHCS 5079: https://www.dhcs.ca.gov/formsandpubs/forms/forms/sudcd/dhcs_5079.pdf

17. 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.

18. 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.

19. 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:

a. 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

b. 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.

20. Staff Termination

Contractor shall inform BHRS, within two (2) business days, 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.

21. 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.

G. 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 at ode@smcgov.org to plan for appropriate technical assistance.

H. 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.

I. Control Requirements

Contractor shall be familiar and implement the laws, regulations, codes and guidelines listed in Attachment L. Contractor shall assure that its Subcontractors are also familiar with such requirements.

Contractor shall establish written policies and procedures consistent with the requirements identified in Attachment L. Contractor shall be held accountable for audit exceptions taken by the State for any failure to comply with these requirements.

DMC Contractor will fulfill the requirements of 42 CFR Part 438 et seq (managed care) that are appropriate to the service or activity covered under this contract.

Attachment L is subject to modifications by federal, state and local regulations that are applicable to the Intergovernmental Agreement.

J. Trafficking Victims Protection Act of 2000

Contractor shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104(g)) as amended by section 1702: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim.

III. PERFORMANCE STANDARDS, GOALS AND OBJECTIVES

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

PERFORMANCE STANDARDS

A. Timely Access to Care: Contractor shall track and document timely access data, including the date of initial contact, the date of first offered

appointment, and the date of first actual appointment, using the UCLA ASAM Level of Care spreadsheet.

1. For Outpatient and Intensive Outpatient Treatment Services, the first appointment shall occur no later than ten (10) days after the initial request for services.

2. For Residential Treatment Services, the first appointment shall occur no later than three (3) days after the referral was received, if the Contractor has capacity to admit the client.

3. For Urgent Treatment Services (Residential Withdrawal Management), the first appointment shall occur within twenty-four (24) hours of the initial request for services, if the Contractor has capacity to admit the client.

B. Transitions Between Levels of Care: Both the admitting and discharging Contractors shall be responsible for facilitating the client's transition between levels of care, including assisting the client in scheduling their first appointment and ensuring a minimal delay between discharge and admission at the next level of care, providing or arranging for transportation as appropriate, and documenting the transition in the client's chart.

1. Transitions between levels of care shall occur within ten (10) business days from the time of the ASAM LOC Re-Assessment indicating the need for a different level of care.

2. At least seventy-five percent (75%) of clients discharged from Residential Treatment are subsequently admitted to another level of care (IOP, OP or Recovery Services) within ten (10) business days from the date of discharge.

3. At least seventy-five percent (75%) of clients discharged from Residential Withdrawal Management care are subsequently admitted to another level of care within ten (10) business days from the date of discharge.

4. At least fifty percent (50%) of clients discharged from Intensive Outpatient or Outpatient Treatment are subsequently admitted to another level of care (including Recovery Services) within ten (10) business days from the date of discharge.

C. Care Coordination: Contractors shall ensure 42 CFR compliant releases are in place for all clients in order to coordinate care. The Contractor shall screen for and link clients with mental health and primary care, as indicated.

1. One hundred percent (100%) of clients are screened for mental health and primary health care needs.

2. At least seventy percent (70%) of clients who screen positive for mental health disorders have documentation of referrals to and coordination with mental health providers.

3. At least eighty percent (80%) of clients who screen positive for primary health care needs have documentation of referrals to and/or coordination with primary care providers.

D. Medication Assisted Treatment: Contractors shall have procedures for referrals to and integration of medication assisted treatment for substance use disorders. Contractor staff shall regularly communicate with physicians of clients prescribed these medications unless the client refuses to sign a Release of Information.

1. At least eighty percent (80%) of clients with a primary opioid or alcohol use disorder will be referred for a MAT assessment and/or MAT services.

E. Culturally Competent Services: Contractors shall be responsible for providing culturally competent and linguistically appropriate services. Translation and interpretation services shall be available to all clients, as needed and at no cost to the client.

1. One hundred percent (100%) of clients who speak a threshold language are provided services in their preferred language.

2. One hundred percent (100%) of clients who read a threshold language are provided written treatment materials in their preferred language.

GOAL AND OBJECTIVE

GOAL: Program participants will achieve a successful treatment discharge.

OBJECTIVE: No less than fifty-seven percent (57%) of participants will have a successful treatment discharge. Successful treatment discharge occurs when a program participant completes his/her treatment/recovery plan or is transferred for continued treatment.

*** END OF EXHIBIT A.2.1 ***

EXHIBIT B.2.1 – ALCOHOL AND OTHER DRUG PAYMENTS AND RATES
CAMINAR, INC.
FY 2019 – 2021

In consideration of the services provided by Contractor in Exhibit A.2.1, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

In full consideration of the services provided by Contractor under this Agreement and subject to the provisions of Paragraph 3 of this Agreement, County shall pay Contractor in the manner described below:

A. Maximum Obligation

The maximum amount that County shall be obligated to pay for all services provided under this Agreement shall not exceed the amount stated in Paragraph 3 of this Agreement. Furthermore, County shall not pay or be obligated to pay more than the amounts listed below for each component of service required under this Agreement. Contractor shall receive monthly payments as outlined below, upon timely submission of reports as outlined in the AOD Policy and Procedure Manual located at: http://www.smhealth.org/bhrs/aod/reqs.

In any event, the maximum amount County shall be obligated to pay for all services rendered under this contract shall not exceed TWENTY MILLION FIVE HUNDRED SEVENTY-THREE THOUSAND FIVE HUNDRED FIFTY-FIVE DOLLARS ($20,573,555).

B. Drug MediCal Organized Delivery System SUD Treatment Services

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed THREE MILLION SEVEN HUNDRED SEVENTY-NINE THOUSAND ONE HUNDRED SEVENTY DOLLARS ($3,779,170) for the term of the agreement.

1. FY 2019 – 2020

Contractor shall be paid a maximum of ONE MILLION EIGHT HUNDRED FIFTY-SIX THOUSAND ONE HUNDRED THIRTEEN DOLLARS ($1,856,113). Contractor shall submit monthly invoices for payment. Invoice amounts shall be for the Contractor actual monthly costs, or an advance payment in the amount of ONE HUNDRED FIFTY-FOUR THOUSAND SIX HUNDRED SEVENTY-SIX DOLLARS ($154,676), whichever is less. Contractor will submit invoices on forms and in manner prescribed by the County.

2. FY 2020 – 2021

   a. For the term July 1, 2020 through December 31, 2020, Contractor shall be paid a maximum of NINE HUNDRED SIXTY-FIVE THOUSAND ONE HUNDRED SEVENTY-NINE DOLLARS ($965,179). Contractor shall submit monthly invoices for payment. Invoice amounts shall be for the Contractor actual monthly costs, or an advance payment in the amount of ONE HUNDRED SIXTY THOUSAND EIGHT HUNDRED SIXTY-THREE DOLLARS ($160,863), whichever is less. Contractor will submit invoices on forms and in manner prescribed by the County.

   b. For the term January 1, 2021 through June 30, 2022, Contractor shall be paid a maximum of NINE HUNDRED FIFTY-SEVEN THOUSAND EIGHT HUNDRED SEVENTY-NINE DOLLARS ($957,879) due to low utilization rates in Recovery Residences. Contractor shall submit monthly invoices for payment. Invoice amounts shall be for the Contractor actual monthly costs, or an advance payment in the amount of ONE HUNDRED FIFTY-NINE THOUSAND SIX HUNDRED FORTY-SIX DOLLARS ($159,646), whichever is less. Contractor will submit invoices on forms and in manner prescribed by the County

3. Where Contractor requires payment advances, Contractor assures the County that an advance is necessary in order to maintain program integrity. Contractor will not use County funds to provide working capital for non-County programs. Where possible, advances will be deposited in interest-bearing accounts, with said interest being used to reduce program costs.

4. County shall make monthly payments to Contractor for invoiced amounts within thirty (30) days of receipt of invoices.

5. Costs for room and board services must be claimed as a separate line item in invoices and reported in cost reports separately and distinctly from residential treatment services using the methodology for claiming and reporting for room and board services as approved by the County.

6. Billing for DMC Services

   a. Contractor shall bill BHRS for services provided to Medi-Cal clients, covered under the DMC-ODS.

   b. Contractor must follow the process established under DHCS ADP Bulletin 11-01, for clients that have other healthcare

coverage (OHC) in addition to Medi-Cal including future DHCS process updates for DMC claims for clients with OHC: http://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-01.pdf.

c. Services covered through another healthcare provider shall not be reimbursed through the County. Contractor shall bill the other healthcare coverage for which the client is a beneficiary. If Contractor is not a member of the provider network for that healthcare coverage, Contractor shall then refer client to the healthcare provider network.

7. DMC-ODS Administrative Requirements

a. Contractor may not use allocated DMC State General Funds to pay for any non-DMC services. In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for MediCal Administrative Activities (MAA).

b. DMC rates are contingent upon legislative action of the annual State Budget and/or the approval of the DMC-ODS plan. All claims must be documented in accordance with DHCS DMC Provider Billing Manual, DMC rules, guidelines, timelines, and must be provided by staff who are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice and/or licensure.

c. Contractor shall prepare and retain for DHCS review as needed the following forms: a) multiple billing overrider certification (MC 6700), document 2K; b) Good Cause Certification (6065A) document 2L(a); and Good Cause Certification (6065B) Document 2LB. In the absence of good cause documented on the GCC 6065 a or b form, claims that are not submitted within thirty (30) days of the end of the month of service will be denied.

d. The existence of good cause shall be determined by DHCS in accordance with Title 22, CCR, Sections 51008 and 51008.5.

e. DMC services are jointly funded by Federal Financial Participation (FFP) and matching State and local dollars. FFP is the Federal share of reimbursement for eligible services delivered to MediCal clients as define by CCR Title 9, Section 1840.1000. Contractor will meet the FFP eligibility criteria.

8. Cost Report / Unspent Funds

a. Contractor shall complete and certify State DMC year-end cost report forms. Contractor shall submit completed forms and certification to County no later than August 30th after the end of the fiscal year.

With the cost report, Contractor shall submit a written reconciliation of the total units of services delivered under this agreement with the total number of units reported by Contractor to the County data system. The County reserves the right to withhold payment due to Contractor under this Agreement or subsequent year's Agreement until such time as Contractor submits the required cost report and reconciliation report to the County.

b. 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 total amount of the unearned funds shall be made by Contractor to County, unless otherwise authorized by the BHRS Director. This payment shall be submitted with the cost report.

c. If the annual cost report provided to County shows that Contractor had costs that were higher than the payments received (and less than the Agreement maximum), Contractor may submit an invoice to the County for any additional amount owed up to the balance of the Agreement maximum. County will make payment for approved costs within forty-five (45) days of receipt of such invoice.

d. Contractor may request that contract savings or "unspent funds" within the Agreement maximum are expended by Contractor in the following year, provided that these funds are expended for SUD services approved by County in accordance with the following procedures. County reserves the right to deny the request and is under no obligation to approve unspent funds from the previous year (no multiple year roll over.)

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

ii. At the time of the submission of the detailed budget and 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 the Director's designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget by expenditure line items. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved. If approved, the Agreement for the succeeding fiscal year will be amended as necessary to include the approved rollover amount.

iii. Unspent funds may only be used for one-time expenses and not for ongoing costs. Unspent funds will be reimbursed based on actual expenditures incurred and submitted as a separate line item in invoices.

9. Additional forms and/or information may be required in support of Cost Report data at discretion of the County.

D. All Services

1. Cost Settlement

Settlements of total amount due to Contractor for services provided will be made at the following times:

a. Filing of monthly Revenues and Expenditures Reports. Contractor shall submit a monthly Revenues and Expenditure Report to the BHRS Program Analyst.

b. Filing of quarterly Budget Monitoring Reports. Contractor shall submit a quarterly Budget Monitoring Report using the BHRS provided template.

c. Filing of Cost Report. At the time that the Contractor submits the DHCS Cost Report to the County, Contractor shall reconcile all actual costs with payments received. Contractor shall submit an invoice to the County for any balance due, or shall submit a check to the County for any unearned amount. Any balances due or unearned amounts will have been adjusted to account for any subsequent known disallowances for DMC services.

DMC Cost Report requirements are described in section V.

d. Subsequent to the filing of the County DMC Cost Report to the State DHCS, there may be a secondary settlement required if it is determined that units and/or costs previously submitted by the Contractor are eligible or ineligible for reimbursement. Notice for any settlement under this provision will be sent by the County to the Contractor within 60 (sixty) days of the time in which the County files the DMC Cost Report.

e. It is anticipated that DHCS will make payment to the County of any outstanding claims approximately eighteen (18) months following the close of the fiscal year. At that time there may be reconciliation with DHCS of outstanding County claims that may result in disallowed units or costs previously submitted for payment. Notices for any settlement under this provision will be sent by County to Contractor within sixty (60) days of receipt from DCHS of the total reconciliation of units of service. The County may choose to appeal any such disallowances, and therefore reserves the right to defer any reconciliation with Contractor until the resolution of any such appeal.

f. A final reconciliation and settlement is anticipated subsequent to the audit of the County's DMC Cost Report by DHCS. Notices for any settlement under this provision will be sent by County to Contractor within sixty (60) days of receipt from DCHS of the final audit determination. The County may choose to appeal any audit disallowances, and therefore reserves the right to defer final reconciliation of payments to Contractor until resolution of any such appeal.

g. If the Contractor has acted in good faith to ensure staff and programs completely comply with County's direction and requirements, to the extent that Contractor audit findings are the result of County's directions and requirements and not from Contractor's errors or omissions, Contractor shall not be held responsible for such audit findings. If the Contractor disagrees with a negative audit finding, Contractor may appeal that decision to the BHRS Director, who shall have final authority to determine Contractor's responsibility for the audit finding.

2. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.

3. Modifications to the allocations in Paragraph A of this Exhibit B.2.1 may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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).

9. At any point during the Agreement term, Contractor shall comply with all reasonable requests by County to provide a report accounting for the Grant Funds distributed by the County to the Contractor to-date.

10. Monthly Invoice and Payment

Contractor shall bill County on or before the tenth (10th) working day of each month following the provision of services for the prior month. 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 one hundred eighty (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 and reports are to be sent to:

County of San Mateo
Behavioral Health and Recovery Services
BHRS Program Analyst
310 Harbor Blvd., Bldg. E
Belmont, CA 94002

Contractor shall set and collect client fees from non Medi-Cal beneficiaries based on the client's ability to pay. The fee requirement shall not apply to prevention and early intervention services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.

11. 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.

12. Adjustments may be made to the total of the Agreement and amounts may be withheld from payments otherwise due to the Contractor for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A.2.1.

13. 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.

14. 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 San Mateo County BHRS Quality Improvement Manager.

Contractor shall maintain for review and audit and supply to County and/or DHCS upon request, adequate documentation of all expenses

claimed pursuant to this Intergovernmental Agreement to permit a determination of expense allowability.

If the allowability or appropriateness of an expense cannot be determined by County or DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles and generally accepted governmental audit standards, all questionable costs may be disallowed by County or DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may be made for the amount substantiated and deemed allowable. Invoices, received from a Contractor and accepted and/or submitted for payment by County, shall not be deemed evidence of allowable Intergovernmental Agreement costs.

It is understood and agreed that failure by the County or Contractor to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the County and/or terminate the Contractor from DMC program participation. If the State or the Department of Health Care Services (DHCS) disallows or denies payments for any claim, County shall repay to the State the federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a).

Reimbursement for covered services, other than NTP services, shall be limited to the lower of:

a. Contractor's usual and customary charges to the general public for the same or similar services;

b. Contractor's actual allowable costs.

15. Substance Abuse Prevention and Treatment Funding

Contractor shall comply with the SAPT Block Grant financial management standards contained in Title 45, CFR, Part 74, Sections 74.21(b)(1) through (4) and (b)(7), and Part 96, Section 96.30.

Pursuant to 42 U.S.C. 300x-31, Contractor shall not use SAPT Block Grant funds provided by the Intergovernmental Agreement on the following activities:

a. Provide inpatient services;

b. Make cash payment to intended recipients of health services;

c. Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;

d. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;

e. Provide financial assistance to any entity other than a public or nonprofit private entity;

f. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see http://grants.nih.gov/grants/policy/salcap_summary.htm;

g. Purchase treatment services in penal or correctional institutions of this State of California; and

h. Supplant state funding of programs to prevent and treat substance abuse and related activities.

16. County May Withhold Payment

Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment 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 BHRS Quality Improvement Manager. Contractor shall meet quarterly with County contract monitor, as designated by the BHRS Deputy Director, Adult and Older Adults, to review documentation and billing reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies.

17. 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.

18. 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.

a. Option One

i. 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 B.2.1. 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.

ii. 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.

a. Option Two

i. 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 B.2.1. 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.

ii. 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.

19. 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.

20. Claims Certification and Program Integrity

a. 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.

b. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A.2.1 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 _____ "

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

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

ii. The beneficiary was eligible to receive services described in Exhibit A.2.1 of this Agreement at the time the services were provided to the beneficiary.

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

iv. 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.

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

vi. 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.

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

d. Except as provided in Paragraph II.F.4. of Exhibit A.2.1 relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

21. Audit Requirements

All expenditures of County realignment funds, state and federal funds furnished to the Contractor are subject to audit by the State. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of the Office of Management and Budget (OMB) 2 CFR 200 and/or any independent Contractor audits or reviews.

In addition to requirements below, Contractor shall be in compliance with federal Single Audit requirements as a designated sub-recipient of federal funding. Contractor agrees to amend this agreement during the contract term to add federal Uniform Guidance compliance requirements.

Objectives of audits may include, but not limited to, the following:

a. To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting;

b. To validate data reported by the Contractor for prospective Intergovernmental Agreement negotiations;

c. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations;

d. To determine the cost of services, net of related patient and participant fees, third- party payments, and other related revenues and funds;

e. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and State Agreement with the State requirements, and/or;

f. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation.

Unannounced visits may be made at the discretion of the State and/or County.

The refusal of the Contractor to permit access to and inspection of electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part constitutes an express and immediate material breach of this Agreement and will be sufficient basis to terminate the Agreement for

cause or default.

County shall monitor the activities of Contractor to ensure that:

a. Contractor is complying with program requirements and achieving performance goals; and

b. Contractor is complying with fiscal requirements, such as having appropriate fiscal controls in place, and using awards for authorized purposes.

Contractor shall be responsible for any disallowance taken by the Federal Government, the State, or the California State Auditor, as a result of any audit exception that is related to the Contractor's responsibilities herein.

Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting single or program-specific audit reports, or failure to comply with all other audit requirements. Should such sanctions be due to noncompliance by the Contractor, such sanctions will be passed on to the Contractor by the County. The sanctions may include:

a. Withholding a percentage of federal awards until the audit is completed satisfactorily;

b. Withhold or disallowing overhead costs;

c. Suspending federal awards until the audit is conducted; or

d. Terminating the federal award.

22. Drug Medi-Cal Financial Audit Requirements

In addition to the audit requirements, the State may also conduct financial audits of DMC programs, exclusive of NTP services, to accomplish any of, but not limited to, the following audit objectives:

a. To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

b. To ensure that only the cost of allowable DMC activities are included in reported costs;

c. To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare

Provider Reimbursement Manual) (CMS- Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov for comparison to the DMC cost per unit;

d. To review documentation of units of service and determine the final number of approved units of service;

e. To determine the amount of clients' third-party revenue and MediCal share of cost to offset allowable DMC reimbursement; and

f. To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.

24. Contractor shall be responsible for any disallowances taken by the Federal Government, the State, or the Bureau of State Audits as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds.

Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within six (6) months from the date of the plan.

25. DMC Record Keeping

Contractor shall maintain sufficient books, records, documents, and other evidence necessary for the State to audit Intergovernmental Agreement performance and Intergovernmental Agreement compliance. Contractor shall make these records available to the State, upon request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, they shall be sufficient to determine if costs incurred by Contractor are reasonable, allowable and allocated appropriately. All records must be capable of verification by qualified auditors.

a. Contractor shall include in any Agreement with an audit firm a clause to permit access by the State to the working papers of

the external independent auditor, and require that copies of the working papers shall be made for the State at its request.

b. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.

c. Accounting records and supporting documents shall be retained for a ten (10) year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the California State Auditor has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not been completed within three years, the interim settlement shall be considered as the final settlement.

d. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.

e. Should Contractor discontinue its contractual agreement with the County, or cease to conduct business in its entirety, Contractor shall provide fiscal and program records for the Agreement period to the County. Records shall be provided in compliance with the State Administrative Manual (SAM), located at http://sam.dgs.ca.gov/TOC/1600.aspx.

The Contractor shall retain all records required by Welfare and Institutions Code section 14124.1, 42 CFR 433.32, and California Code of Regulations, Title 22, Section 51341.1 et seq. for reimbursement of services and financial audit purposes.

f. In the expenditure of funds hereunder, and as required by 45 CFR Part 96, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

g. Contractor shall retain records of utilization review activities

required for a minimum of ten (10) years.

In addition, Contractor shall, upon request, make available to the County and/or the State their fiscal and other records to assure that Contractor has adequate recordkeeping capability and to assure that reimbursement for covered DMC services is made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

- Provider ownership, organization, and operation;
- Fiscal, medical, and other recordkeeping systems;
- Federal income tax status;
- Asset acquisition, lease, sale, or other action;
- Franchise or management arrangements;
- Patient service charge schedules;
- Costs of operation;
- Cost allocation methodology;
- Amounts of income received by source and purpose; and
- Flow of funds and working capital.

26. Dispute Resolution Process

a. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, County shall, at the Contractor's request, request an appeal to the State. Contractor must file such an appeal of State audit findings with the County. The appeal must be in writing and sent to the County AOD Administrator within thirty (30) days of receipt of the audit findings.

b. When a financial audit is conducted by the County with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, the Contractor may file a written appeal by email or facsimile with the Director of Behavioral Health and Recovery Services. The appeal must be sent within thirty (30) days of receipt of the audit findings from the County.

The County will respond to an appeal within ten (10) business days of receiving it, and the County may, at its election, set up a meeting with the Contractor to discuss the concerns raised by the appeal. The decision of the County will be final. The appeal letter must be sent as follows:

Director, Behavioral Health and Recovery Services
c/o Ritu Modha
rmodha@smcgov.org
Facsimile: 650-573-2110

*** END OF EXHIBIT B.2.1 ***

SAMSHA CERTIFICATIONS – ATTACHMENT 2

CERTIFICATIONS

Certification Regarding Lobbying

1) No federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person influencing or attempting to influence an officer or employee of any agency, a Member of Congress, and officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form To Report Lobbying" in accordance with its instructions.

3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and is disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 for each such failure.

Salary Cap

The undersigned certifies that no grant funds will be used to pay an individual salary at a rate in excess of $192,300 per year, not including benefits.

Drug Free Work Environment

The undersigned certifies that reasonable efforts are made to maintain a drug-free work place in all programs supported y the Block Grant funds.

SAMSHA CERTIFICATIONS – ATTACHMENT 2 (CONTINUED)

Certification Regarding Debarment Suspension Ineligibility And Voluntary Exclusion – Lower Tier Covered Transactions

1) The prospective lower tier participant certified, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this transaction by any Federal department or agency.

2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal/application.

Mark Cloutier Digitally signed by Mark Cloutier
D.N. cn=Mark Cloutier, o=Carminar, email=mclouter@carminar.org, c=US
Date: 2021.01.04 13:01:19 -08'00'

Signature of Official Authorized To Sign Application

Date

SAMSHA CERTIFICATIONS – ATTACHMENT 3

Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State of local governments, by Federal grant, contract loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children's services provided in private residences, portions of facilities used for inpatient drug, or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offer or/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any sub awards which contain provisions for children's services and all sub recipients shall certify accordingly.

Mark Cloutier Digitally signed by Mark Cloutier DN: cn=Mark Cloutier, o=Caminar email=mcloutier@caminar.org, c=US Date: 2021.01.04 13:37:41 -08'00'

Signature of Official Authorized To Sign Application

Date

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Attachment T

BHRS Contractors - Technology Supports for Clients

Frequently Asked Questions (FAQs)

Through the Mental Health Service Act (MHSA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, BHRS has secured funding for BHRS Contractors to provide **technology supports (devices and data plans), for one year**, for clients and family members of clients that would benefit from telehealth and/or other behavioral health services but, do not have the resources to purchase the technology needed.

With the support of Help@Hand[1] partners, BHRS selected a federally-subsidized program through T-Mobile that offers a low-cost data plan (internet service) along with free refurbished phones/tablets. Given the limited resources, we ask that you please prioritize this benefit for clients and families most in need and who are unable to take advantage of other low-cost and/or income-based services.

Q: Who is eligible for this funding?

A: BHRS Contractors that provide direct treatment and/or recovery-focused behavioral health services to clients who are struggling to stay connected to services due to cost of purchasing internet service and/or the devices needed to participate. BHRS Contractors were asked to complete a survey by September 11, 2020 to be considered for funding.

Q: Our agency was awarded funding, what's next?

A: BHRS will amend contracts of eligible providers to add the funding awarded. Contractors will then work directly with T-Mobile to purchase the internet service on free devices available. Contractors will also be responsible for distributing the devices to their clients.

The T-Mobile government representative is Marc Cox, Government Account Manager State & Local Government, Public Safety, Education. He will be your contact once your contract amendment is executed for this benefit. He can be reached by mobile at 408-590-4605 and/or email at marc.a.cox@t-mobile.com. *Please reach out to him directly and mention that you are under the **San Mateo County Government Plan**, this will ensure you receive the same government rates we have negotiated.*

Q: Can other technology accessories be purchased with the funding?

A: MHSA One-Time funding can be used to purchase data plans on the free T-Mobile phones and tablets and to purchase headphones, screen protectors, device covers, and/or other device accessories as needed to support client use of the devices to participate in services. CARES Act funding can only be used for purchasing the data plans on free T-Mobile tablets. The funding

[1] San Mateo County BHRS is one of 12 city/counties participating in Help@Hand, a California collaborative created to determine if and how technology fits within the behavioral health system of care; https://helpathandca.org/

amounts you were awarded under MHSA and CARES Act will be included in your contract amendment.

Q: What happens after the one-year of technology supports to clients?

A: The current funding was estimated based on one year of service only to support clients and families given the COVID-19 pandemic. After the one-year ends, contractors can take on the cost if they have funding available OR T-Mobile representative will work with clients/families to transfer the service to an individual account for a similar low-cost option if they would like to keep the device and have the means to do so.

Q: How did BHRS determine how much funding to allocate to each contractor?

A: Based on the number of requests and funding available, BHRS determined the allocation amount for each agency. Fifteen contracted agencies and BHRS programs were allocated funds. $339,000 of MHSA One-Time funding is available to purchase data plans, headphones, screen protectors, device covers, and/or other device accessories as needed to support client participation in services. $69,000 of CARES Act funding is available for purchasing the data plans on free T-Mobile tablets.

Q: How many devices (phones and/or tablets) will contractors be able to purchase?

This depends on the funding amount we are able to allocate to your agency and the types of devices and/or other accessories you decide to purchase for your clients. T-Mobile offers low-cost data plan options for refurbished Samsung and Apple phones and tablets; specific brand models offered by T-Mobile depend on availability and rates vary. The T-Mobile program does not include other accessories, but these can be purchased with MHSA funds through other sources (e.g. Amazon, etc.)

Q: What is included with the data plan?

A: Currently, the following is included with the cost of the data plans available.

- Free refurbished device.
- Basic tech support provided by T-Mobile representatives.
- Unlimited Voice, Unlimited Messaging, Unlimited LTE Data, 11GB Mobile Hotspot, US/Canada/Mexico calls, Voicemail & Caller ID.
- Staging (pre-loading phones with selected applications "apps"), upon request.
- No other fees, no overages. Clients are unable to incur additional costs on the plan.
- There is no contract, no set-up fees, no shipping fees, no taxes, and no termination fees.
- Lost, stolen, damaged phones can be shut down/cancelled (no contract, no termination fees) and a new phone and service requested if needed.
- Screen protectors/cases are not included but, can be purchased separately. Amazon provides low cost options for a dual screen protector and case pack.

For an additional low-cost, there is the option to have an organizational mobile centralized control through a platform/portal (Mobile Device Management /MDM) that would allow your

agency to monitor usage, push out apps, shut down, cancel, add controls, etc. Please speak to the T-Mobile representative if you are interested in this service.

Q: Are there free or low-cost, income-based services are available to clients if they are able to purchase their own data plans?

A: Yes, information on government subsidized programs for clients can be found here: https://www.freegovernmentcellphones.net/states/california-government-cell-phone-providers.

Q: Why T-Mobile, are we able to work with other phone/internet providers?

A: This program is part of Western States Contracting Alliance and the National Association of State Procurement Officials (WSCA-NASPO), which offers purchasing benefits to authorized non-profits and governmental entities. All eligible entities can use the contract(s) that WSCA-NASPO has negotiated with mobile phone/internet providers to purchase discounted monthly services, simplifying the procurement process and eliminating the need to go out to RFP. BHRS selected T-Mobile based on the lower costs overall associated with the program including free activation, free replacements and available tech support to clients.

Additional Questions?

Please contact Doris Estremera, MHSA Manager at mhsa@smcgov.org if you have additional questions about this effort and/or the process to access funding for client technology supports.

[Agency LOGO]

ATTACHMENT U

SAMPLE
Device User Agreement and Waiver Form

Purpose

The purpose of this agreement is to support the safety and accountability of participants while using devices (phones or tablets) provided by [Agency] for participation in behavioral health treatment and recovery services.

Agreement

- The primary use of the device(s) must be to participate in behavioral health treatment and recovery.
- [Agency] reserves the right to end the data plan service on the device(s) and revoke the device(s) at any time; this could include not participating in any scheduled telehealth appointments or online recovery/support groups as agreed upon.
- Tablet(s) loaned by [Agency], for participation in a time-limited group session for example, must be returned to a staff member when requested.
- Device(s) must never be used when they could pose a security or safety risk.
- Device(s) must never be used while driving a vehicle, operating equipment, or in any situation where using the device may cause an accident.
- Device(s) must never be used for inappropriate activity including illegal or dangerous activities or for purposes of harassment.
- Device(s) must only be used by the individual (client or parent/caregivers of youth clients)to whom it is assigned to by [Agency].
- Improper use of the device(s) will result in loss of privileges for using the device.
- The data plan (internet) service on the device(s) is good for one-year from the date the device(s) is issued, as indicated below. After the one-year ends, unless otherwise communicated by [Agency], individuals can choose to transfer the low-cost data plan service to a personal, non-[Agency] account.
- Lost, stolen, or damaged device(s) must be reported immediately by calling [Agency contact].

By signing this form, you agree to the [Agency] policy governing phone and/or tablet devices provided by the [Agency].

Device Phone Number: _____ Device Received (circle one): Phone / Tablet

[Agency LOGO]

Device Issued to Participant:

_____ _____

Print Name of Client Participant Signature

_____

Date Issued

_____ _____

Print Name of Staff Staff Signature

_____

Date

□ Copy given to client

Device Returned:

_____ _____

Print Name of Participant Participant Signature

_____

Date

_____ _____

Print Name of Staff Staff Signature

_____

Date

□ Copy given to participant

Notes:

Attachment V - Technology Supports – Monthly Reporting Form

DEVICE TRACKING LOGS – CARES Act

Reporting Month:Choose an item.

Client(s) Name (client that received tablet during the reporting month):

1.	14.
2.	15.
3.	16.
4.	17.
5.	18.
6.	19.
7.	20.
8.	21.
9.	22.
10.	23.
11.	24.
12.	25.
13.	26.

Number of devices assigned to support client services on-site (during the reporting month): _____

This section is for devices not given to clients to take home, but rather assigned to support client-related services such as, a shared tablet at residential facility or lobby, to facilitate group sessions, field services, etc.

1.	Tablet used for (service provided):	Tablet primary location/site:	Number of clients served (during the reporting month):
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Attachment V - Technology Supports – Monthly Reporting Form

DEVICE TRACKING LOGS – MHSA One-Time Funding

Reporting Month:Choose an item.

Total number of T-Mobile For Government phones ordered: _____

Total number of tablets ordered:_____

Other device accessories purchased to support client participation in services (headphones, screen protectors, device covers, and/or other device accessories)

Type of Accessory Purchased	Units Purchased	$ Cost per Unit	Total $Amount
1.			
2.			
3.			
4.			

Clients that received a device (during the reporting month):

Client(s) Name	Type of device received (tablet or phone) and/or accessories
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

Number of devices assigned to support client services on-site (during the reporting month): _____
This section is for devices not given to clients to take home, but rather assigned to support client-related services such as, a shared tablet at residential facility or lobby, to facilitate group sessions, field services, etc.

	Tablet used for (service provided):	Tablet primary location/site:	Number of clients served (during the reporting month):
1.			
2.			
3.			
4.			
5.			
6.			