THIRD AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND STARVISTA

THIS THIRD AMENDMENT TO THE AGREEMENT, entered into this _____ day of _____, 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and STARVISTA, 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 ("Original Agreement") for professional services on June 26, 2012 for a maximum obligation of $3,937,108; and

WHEREAS, on August 6, 2012, your Board approved an amendment to the Agreement to include substance abuse confidentiality language as required by federal regulation 42 CFR Part 2, with no change to the term of the agreement or the maximum obligation.

WHEREAS, on September 10, 2013, your Board approved an amendment to the Agreement increasing the maximum obligation by $2,936,846, and extending the term of the agreement for Alcohol and Drug Services to December 31, 2013 and through June 30, 2014 for all other services.

WHEREAS, it is now necessary and the mutual desire and intent of the parties hereto to amend the agreement a third time to increase the maximum obligation by $3,165,349 to a new maximum of $10,039,303 and extend the term of the agreement for AOD services to June 30, 2015, and all other services will remain in effect through June 30, 2014.

WHEREAS, the parties wish to Amend and clarify that Original Agreement.

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

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

   In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A," County

shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B." The County reserves the right to withhold payment if the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed TEN MILLION THIRTY-NINE THOUSAND THREE HUNDRED THREE DOLLARS ($10,039,303).

2. Paragraph 4. Term and Termination is hereby deleted and replaced with the Paragraph 4. Term and Termination below:

Subject to compliance with all terms and conditions, the term of this Agreement shall be from July 1, 2012 through June 30, 2015 for AOD services and July 1, 2012 through June 30, 2014 for all other services.

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

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

2. Exhibit A-2-1 remains unchanged, appending Exhibit A-2-2 attached hereto and the remaining Exhibits shall remain unchanged.

3. Exhibit B-2-1 remains unchanged, appending Exhibit B-2-2 attached hereto and the remaining Exhibits shall remain unchanged.

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

SIGNATURE PAGE TO FOLLOW.

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

COUNTY OF SAN MATEO

By:_____
President, Board of Supervisors
San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

STARVISTA

Contractor's Signature

Date: 10/28/13

EXHIBIT A-2-1
BHRS ALCOHOL AND OTHER DRUG SERVICES
JULY 1, 2012 – DECEMBER 31, 2013

In consideration of the payments set forth in Exhibit B-2-1, Contractor shall provide the following services specified in this Exhibit A-2-1.

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

In providing its services and operations, Contractor will maintain compliance with requirements of the Alcohol and Other Drug (AOD) Provider Handbook including additions and revisions, incorporated by reference herein. Reimbursement is contingent upon client eligibility and compliance with referral and authorization procedures as outlined in the AOD Provider Handbook located at http://www.aodsystems.com/SMC/Index.htm.

A. Fixed Rate Services

1. NRC Insights Outpatient Treatment
2. County Funded Outpatient Treatment
3. County Funded Camp Glenwood
4. MHSA GIRLS Program
5. MHSA GIRLS/COD
6. CalWORKs WEC Day Treatment
7. Sobering Station
8. County Funded WEC Day Treatment
9. MCE County Match Outpatient and Day Treatment

B. Fee For Service

1. Drug Court and 11550 Funded Services

   a. Outpatient Treatment Services
   One (1) hour individual and/or group counseling session provided for CDCI/DCP funded outpatient alcohol and drug treatment and recovery services.
   b. Day Treatment
   Day Treatment Services per individual for each visit day provided for CDCI/DCP funded alcohol and drug day treatment and recovery services.
   c. Drug Testing
   The rate will not exceed the actual cost of the drug screen, plus an administrative fee as specified in the Contractor's approved Drug Testing Plan.
   d. Individual and Family Therapy
   Ancillary counseling services refer to counseling services, not

directly to substance abuse treatment. These services are necessary for the continuum of the individuals' success. Services shall include the following:

i. Ancillary counseling, including individual, group, and/or conjoint family counseling.
ii. The ancillary counseling services will be provided by Licensed Marriage Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Psychologist, or other licensed clinical professional staff. Any counseling services provided by non-licensed staff shall be under the supervision of a licensed professional and meet the standards as required by the state licensing guidelines.
iii. Contractor shall have the appropriate infrastructure to provide services in County identified threshold languages, such as Spanish, Tagalog, Mandarin and Cantonese.
iv. Program participants' AOD Case Manager will monitor the progress of each participant referred to ancillary counseling services. The licensed clinical professional will provide frequent, regular updates regarding the participants' participation to the Case Manager.

2. Achieve 180

a. Outpatient
   i. One and one half (1½) hour group counseling session per individual provided within the approved treatment period for Achieve 180 Re-Entry funded outpatient alcohol and drug treatment and recovery services.

   ii. One half (1/2) hour individual counseling session per individual provided within the approved treatment period for Achieve 180 Re-Entry funded outpatient alcohol and drug treatment and recovery services.

b. Day Treatment Services
   i. Intensive Outpatient services are per individual for each visit day provided for A180 funded alcohol and drug treatment and recovery services. Services must be provided a minimum of three hours per day, with a minimum of three visit days per week.

3. Medicaid Coverage Expansion (MCE) Health Coverage

Behavioral Health & Recovery Services (BHRS) will, at its discretion, reimburse Contractor for services provided to Medicaid Coverage Expansion (MCE) beneficiaries. Detailed descriptions of specific

treatment services for the modalities listed below are outlined in the AOD Provider Handbook. Substance use treatment modalities provided under the MCE program include:

a. Outpatient Services
b. Intensive Outpatient Services

4. Criminal Justice Realignment

Contractor shall provide authorized services to individuals meeting the Criminal Justice Realignment (CJR) eligibility criteria as determined by AB 109 and AB 117 and referred by the CJR program.

Substance use disorder (SUD) treatment shall be provided to eligible offenders based on treatment need with available funding resources. A full continuum of SUD treatment services are available to CJR clients based on assessed treatment need.

Contractor will track and report all CJR client services in accordance with the local Community Corrections Partnership (CCP) requirements as described in the AOD Provider Handbook. Contractor may provide the following services to CRJ clients:

a. Outpatient Treatment Services
A minimum of one group counseling session, of one and one half (1½) hours per week will be provided to each approved and authorized CJR participant and funded as part of CJR outpatient alcohol and drug treatment and recovery services.
A minimum of one half (½) hour individual counseling session per individual provided within the approved treatment period for CJR funded outpatient alcohol and drug treatment and recovery services.

b. Day Treatment Services
Intensive Outpatient services are per individual for each visit day provided for CJR funded alcohol and drug treatment and recovery services. Services must be provided a minimum of three hours per day, with a minimum of three visit days per week.

C. Description Of Unique Program Services

1. Archway

Archway provides outpatient substance abuse treatment and recovery services to clients who are participating in Proposition 36 and are referred by the Probation or Parole Departments, and to clients

mandated to complete one of the following: Wet & Reckless, First Offender Program, Anger Management, Deferred Entry of Judgment, or Domestic Non-Violence Program. Services are available to clients in English and Spanish. Archway's outpatient program is a minimum of twelve (12) weeks. Clients attend weekly group and individual sessions, and are required to complete a minimum of six (6) community support meetings.

2. First Chance Outpatient Services

   First Chance Outpatient Services (FCOS) provides outpatient substance abuse treatment, recovery and mental health and recovery services to clients participating in Proposition 36 or Drug Court, and who are referred by Probation, Parole, or AOD. FCOS program is a minimum of twelve (12) weeks and is designed for clients with co-occurring mental health and substance abuse disorders. The number of required individual and group sessions are customized according to the client's individual need. The program uses a harm reduction model while challenging clients to attain sobriety.

3. Insights

   Insights provides outpatient substance abuse treatment and recovery services to adolescent clients and their families. The program is a minimum of eight (8) weeks, but is often extended based upon client need. Services include family assessments, adolescent assessments, family education groups, group counseling, individual counseling, and family counseling sessions and mental health services. All services are provided on-site.

4. Girls Program

   The GIRLS Program is a court-mandated outpatient substance abuse treatment recovery and mental health program that provides assessment, counseling and case management services for adolescent girls aged thirteen (13) through eighteen (18) with co-occurring substance abuse and mental health disorders. Services include family assessments, adolescent assessments, family education groups, group counseling, individual counseling, and in-home family counseling sessions.

5. Camp Glenwood

   Camp Glenwood services include weekly psycho-educational and group counseling services to adolescent boys incarcerated at Camp Glenwood.

6. Women's Enrichment Center

   The Women's Enrichment Center (WEC) provides intensive day substance abuse treatment and recovery mental health services to adult women with co-occurring substance abuse and mental health disorders. Clients are either referred by or eligible for services from CalWORKs and/or Children and Family Services. WEC coordinates with SMC, BHRS and other providers to ensure ongoing planning, coordination and services that address the needs of WEC clients. The program is a minimum of ten (10) weeks. The length of time any individual participant is in the program is based upon the client's need. Clients attend treatment five (5) days a week for three (3) hours per day, and receive: intensive case management services, group counseling, weekly individual counseling, psycho-educational group classes, supportive services such as transportation to and from treatment, light breakfast and lunch.

7. First Chance Sobering Station

   First Chance Sobering Station provides a sobering facility that operates twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days of the year. This facility provides temporary shelter, individualized substance abuse/dependence assessment, observation, recovery counseling and referral services for ongoing treatment, and twelve (12)-Step meetings for all individuals admitted to the facility.

   First Chance Sobering Station services are available to individuals referred by participating law enforcement agencies, San Mateo County Health Services, and partnering substance abuse treatment and recovery agencies providing residential and intensive day treatment services. Partnering agencies may access the First Chance Sobering Station services for clients in need of a temporary safe shelter until the client sobers up and is able to be admitted or re-admitted into treatment. To access services, the partnering agency will transport the client to the First Chance Sobering Station and remain present with the client until admitted into the Sobering Station, in accordance with the StarVista - First Chance Sobering Station Program Policy.

8. Non-Reimbursable Services

   a. Driving Under The Influence (DUI)
      In accordance with the AOD Provider Handbook, Contractor will provide the DUI program services to clients who have been referred by the Department of Motor Vehicles, Probation, and the Superior Courts.

b. Deferred Entry of Judgment (DEJ)
In accordance with the AOD Provider Handbook, Contractor will provide the DEJ to clients who have been referred by the Probation Department.

9. Wec Co-Occuring Mental Health Services

Mental Health Gender Specific Co-Occurring services will be provided by StarVista through the Women's Enrichment Center Mental Health Clinic. Women's Enrichment Center provides trauma informed co-occurring services for clients dealing with Mental Health and Substance Abuse conditions. Expected complex conditions of clients referred for treatment are severe emotional dysregulation, history of trauma, domestic violence, substance abuse, unstable housing, employment issues, treatment compliance issues, and medical issues.
Contractor will admit individuals, who are referred by BHRS. The length of treatment may vary according to the specific need of each program participant however the services will typically last at least ten (10) weeks. Contractor will provide the following services at mutually agreed upon location(s) in San Mateo County to individuals who are deemed eligible for Mental Health funded services.

a. Description of Services
Contractor will make services available five (5) days per week. Mental health services will be provided five (5) days a week to Mental Health Clients in the morning. In the afternoon, the women with co-occurring conditions have the option of participating in substance abuse treatment.

Contractor's intensive outpatient treatment services for program participants with co-occurring disorders will provide the following services, determined by medical need, to program participants:

i. Intake and assessment, plan development, rehabilitation, group rehabilitation, therapy, group therapy, family therapy and collateral therapy.

II. PRIORITY POPULATIONS

Contract funds must be used to serve priority population clients. Specifically, Contractor will give priority admission to:

A. Populations required by Substance Abuse Prevention and Treatment (SAPT) Block Grant;

B. Clients with MCE health insurance coverage;

C. AOD treatment and recovery priority populations as outlined in Strategic Directions 2010;

D. San Mateo County residents who are referred by BHRS;

E. Referrals from other San Mateo County AOD providers, including the Methadone Clinic, Palm Avenue Detox, and First Chance Sobering Station referrals;

F. Shelter referrals within San Mateo County.

III. ADMINISTRATIVE REQUIREMENTS

A. System-Wide Improvements

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

1. Standards of Care

The County has identified specific Standards of Care (SOC) for treatment services, which incorporate scientific research, and clinical practice, which has been proven effective in the provision of services to clients receiving treatment services. SOC are guidelines for providing comprehensive, client centered, culturally competent screening, assessment and treatment for clients with substance abuse and/or substance dependence/addiction or co-occurring disorders.

Contractor will work towards full compliance with the SOC, specifically:

a. Contractor will continue to develop and implement the activities and achieve the objectives described in the approved San Mateo County AOD SOC implementation work plan.
b. In providing its services and operations, Contractor will maintain compliance with requirements of the AOD Provider Handbook, including additions and revision, which is incorporated by reference herein.
c. Contractor will report quarterly on SOC implementation progress to the assigned AOD Analyst.

2. Continuous Quality Improvement

To enhance the quality and efficiency of services, Contractor will have an established Continuous Quality Improvement (CQI) program. CQI program must include a QI committee made up of staff from all levels that guide the development and implementation of the QI Plan.

Contractor has established a mechanism whereby contractors will identify processes and practices at the organizational level which create inefficiencies and/or present barriers to client engagement, enrollment and retention in treatment.

a. Contractor will develop and implement a Quality Improvement plan with an emphasis on continuous quality improvement, quality review, and quarterly utilization.
b. Contractor will solicit feedback from service recipients on an annual basis, at minimum. Client feedback process may include but is not limited to: focus groups and client satisfaction surveys.
c. Contractor will implement a process to share client feedback with the Quality Improvement committee. Consideration of client feedback will be incorporated into future QI plans.
d. Contractor shall report quarterly to the assigned AOD Analyst on QI plan implementation, progress and client feedback results.
e. Contractors receiving MHSA funding to treat clients with COD shall comply with additional reporting requirements as outlined in the online AOD Provider Handbook.

3. Co-occurring/Complex Disorders

Contractor will work to improve treatment outcomes for co-occurring/complex clients by providing the following:

a. Contractor will participate as a Change Agent and will delegate participation in monthly activities to effect the changes necessary to maintain and enhance Co-occurring Disorders (COD) capability.
b. Contractor will establish a COD work plan that continues to assess and address the needs of complex clients. This COD work plan may be a part of the Contractor's Quality Improvement program, Standards of Care Work Plan, or it may be a separate process.
c. Contractor will report quarterly to the assigned AOD Analyst on the progress and outcomes of the COD work plan.
d. Contractors receiving Mental Health Services Act (MHSA) funding to treat clients with COD shall comply with additional reporting requirements as outlined in the online AOD Provider Handbook.

4. AVATAR Electronic Health Record

Contractor worked collaboratively with BHRS in the implementation of the new system by:

a. Contractor will participate in the development, training, implementation and utilization of the required AVATAR system.
b. Contractor will maintain compliance with all documentation, reporting, billing and all other data requirements as required in the AOD Provder Handbook, including additions and revision, which is incorporated by reference herein.

c. Contractor will continue to use the DAISY data system for all reporting requirements through June 30, 2013.
d. Contractor shall enter client service data into Avatar for service being provided under County contract and includes: date of service, service type, service units and service duration.
e. Contractor shall enter client wait list data into Avatar. This information will be used to determine unmet treatment needs and wait times to enter treatment.

B. Qualified Service Organization

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

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, problem resolution, and utilization review; and

6. Education, training and technical assistance as needed.

In addition, BHRS:

1 Acknowledges that in receiving, storing, processing, or otherwise using any information form the alcohol/drug program about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;

2. Undertakes 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.

C. Building Capacity

The County seeks to build capacity and increase access to treatment

services for San Mateo County residents. Contractor will work with BHRS to maximize the revenues and increase access to care in the following ways:

1. MCE

   Contractor will work in partnership with BHRS to provide substance use disorder treatment services to beneficiaries of MCE. All services will be delivered in compliance with BHRS policies and procedures found in the AOD Provider Handbook and the BHRS Documentation Manual located at:
   http://www.co.sanmateo.ca.us/Attachments/health/pdfs/bhrs/ContractAgencies/BHRSDocManual.pdf.

2. Other Revenue Enhancement

   Contractor will work in conjunction with AOD to assess whether contracted agency is ready to expand services to other Medi-Cal funded services or other new revenue opportunities.

D. MCE Program Requirements

1. Contractor will screen all incoming clients for health coverage, including MCE eligibility and current MCE enrollment. MCE client eligibility shall be verified prior to service provision;

2. Contractor will facilitate enrollment into MCE, ACE, Medi-Cal and other health coverage programs for clients who are likely eligible for public benefits but not enrolled;

3. Contractor will not charge clients with MCE eligibility for substance use treatment services;

4. Contractor will request and obtain modality and service authorizations and reauthorizations for MCE enrolled clients from BHRS;

5. Contractor will document and provide authorized services to MCE clients in compliance with BHRS documentation guidelines;

6. Contractor will track and report on services and submit invoices for client MCE services provided following required policies and procedures;

7. Contractor will correct and resubmit disallowed claims, as requested;

8. Contractor will ensure that personnel delivering direct services to

clients will have the appropriate professional license and/or certification as outlined in the AOD Provider Handbook.

E. CalWORKs Program Requirements

Contractor will collect the following information and report it on a monthly basis: the client's name, DOB, Avatar ID#, CalWORKs/CalWIN#, Medi-Cal/BIC# (if applicable), case worker name, admission date, discharge date, the number of bed days, visit days, and/or staff hours including individuals and group visits, and the referring agency.

Contractor will collect the following outcomes data on each client exiting treatment, and report it on a quarterly basis:

1. Employment status

2. Housing status

3. Status of current alcohol or other drug use

Further information on reporting forms and verifying clients' CalWORKs eligibility can be found on the AOD Provider Handbook.

F. Cultural Competency

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

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 Program Manager and the Health Equity Initiatives Manager (HEIM) by September 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;
   b. Contractor forum for discussing relevant and appropriate cultural competence-related issues; (such as a cultural competence committee)
   c. Collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation;
   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 with clients in a culturally and linguistically appropriate manner);

e. Staff training plan related to cultural competency. Contractor will ensure that all program staff receives 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.

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 for the term of the Agreement. Contractor shall submit to BHRS ODE by March 31st, a list of staff who have participated in these efforts. For more information about the Cultural Competence Council (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, the contractor is expected to contact Access Call Center or their BHRS 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. Technical Assistance

   Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the Program Manager and HEIM (jafrica@smcgov.org) to plan for appropriate technical assistance.

G. Administering Satisfaction Surveys

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

H. Retention of Records

Paragraph 13 ("Retention of Records") of the Agreement and Paragraph II.4. of Exhibit B-2-1 notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary records (including medical and/or clinical records) for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18^{th}) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.

I. Ineligible Employees

BHRS requires that contractors identify the eligibility status of employees, interns or volunteers prior to hiring and on an annual basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting form, Policy #93-11) should a current employee, intern or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns and volunteers by using the following websites:

1. Office of the Inspector General

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

2. California Department of Health Care Services

   Contractors providing state funded health services may not employ any persons deemed an Ineligible Person by the California Department of Health Care Services (DHCS) in the provision of services for the County through this agreement. Any employee(s) of contractor determined to be an Ineligible Person will be removed from

responsibility for, or involvement with County clients or operations. An "Ineligible Person" is an individual who has been (1) convicted of a crime involving fraud or abuse of the Medi-Cal program, or (2) suspended from the federal Medicare program for any reason. Ineligibility may be verified by checking: http://files.medi-cal.ca.gov/pubsdoco/publications/bulletins/part1/part1bull_l.asp

J. Licensing Reports

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

K. Documentation of Services

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

L. Certification

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

M. Retention of Records

Paragraph 13 ("Retention of Records") of the Agreement and Paragraph II.4. of Exhibit B-2-1 notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary records (including medical and/or clinical records) for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18^{th}) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.

N. Administering Satisfaction Surveys

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

O. Advance Directives

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

P. Beneficiary/Patient's Rights

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

Q. 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.

R. Compliance Plan and Code of Conduct

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

S. Fingerprint Compliance

At County's sole discretion, Contractor certifies that its employees and/or its subcontractors, assignees, and volunteers who, during the course of performing services under this Agreement, have contact with children or any person under his or her care will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of children or individuals with whom Contractor's employees and/or its subcontractors, assignees, or volunteers have contact. If said employees and/or subcontractors, assignees, and volunteers have such a criminal history, they shall not have contact with children or others who receive

services through this agreement. Fingerprint information received from the Department of Justice (DOJ) shall be retained or disposed of pursuant to DOJ directive.

T. Credentialing

Contractor is responsible for implementing a process to verify, at time of employment, the credentials of its clinical staff (or obtain a waiver). All clinical personnel must comply with HIPAA regulations to obtain a National Provider Identifier (NPI) number. The license and NPI information shall be reported to the County through the completion of a County provided credentialing form and submitted to the BHRS Quality Management team. Thereafter, on a yearly basis, Contractor is responsible to conduct a re-credentialing check verifying the NPI number, and ensure that qualification standards have been met and all applicable licenses are current.

U. Staff Termination

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

V. 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.

EXHIBIT A–2–2 – SERVICES
STARVISTA
BHRS ALCOHOL AND OTHER DRUG SERVICES
JANUARY 1, 2014 – JUNE 30, 2015

In an effort to meet healthcare reform guidelines, Behavioral Health and Recovery Services (BHRS) is focusing on the development and integration of services such as: primary care and behavioral health care services, system and service coordination, health promotion, prevention services, screening and early intervention, treatment services, resilience and recovery support, social integration promotion, employment services, housing and educational services, and services supporting optimal health and productivity. A full range of high quality services is necessary to meet the varied needs of County residents, including: age range, gender, cultural needs, and the promotion of healthy behavior and lifestyles (a primary driver of health outcomes). BHRS anticipates that the roles and responsibilities associated with the change in structure, financing and operation of the redesign may fluctuate or be re-clarified.

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

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

In providing its services and operations, Contractor will maintain compliance with requirements listed in the AOD Provider Handbook including additions and revisions, incorporated by reference herein. Reimbursement is contingent upon client eligibility and compliance with referral and authorization procedures as outlined in the AOD Provider Handbook located at: http://smchealth.org/bhrs/aod/handbook.

A. SERVICES

Behavioral Health and Recovery Services in partnership with community based contracted providers, maintains county-wide comprehensive, integrated, substance use disorder treatment, and recovery supports. These efforts focus on making treatment and recovery services accessible and available for San Mateo County residents in need of treatment, and to improve the core life domains of AOD clients.

1. Minimum Treatment Services

Contractor shall provide Substance Abuse Treatment and Recovery Services in an alcohol and drug free environment with structure and supervision to further a participant's ability to improve his/her level of functioning. A program providing services to San Mateo County residents must be certified and/or licensed by Department of Health Care Services (DHCS) Licensing and Certification Division.

a. Outpatient Services
Outpatient services consist of intake, assessment, recovery or treatment planning, psycho-education, process and support groups, individual counseling, case management, continuing care plans, aftercare, and ancillary services. Contractor is required to provide a minimum of two (2) group counseling sessions per thirty (30) day period. Individual counseling shall be provided for each client, at a minimum of thirty (30) minutes bi-weekly, or one (1) hour per month. Perinatal providers must be in compliance with DHCS's Perinatal Services Network (PSN) guidelines (Provide link) and Adolescent Providers shall also adhere to the Youth Treatment Guidelines set forth by the DHCS (Provide link).

b. Day Treatment Services
An outpatient alcohol and/or other drug service that is provided to clients at least three (3) hours per day and at least three (3) days per week, for a minimum of nine (9) direct service hours per week.

c. Individual Family Therapy
Ancillary therapy services refer to services, not directly to substance abuse treatment. Services shall include the following:

i. Ancillary counseling, including individual, group, and/or conjoint family counseling/therapy.
ii. The ancillary counseling services will be provided by Licensed Marriage Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Psychologist, or other licensed clinical professional staff. Any counseling services provided by non-licensed staff shall be under the supervision of a licensed professional and meet the standards as required by the state licensing guidelines.
iii. The licensed clinical professional will provide frequent, regular updates regarding the participants' participation to the Case Manager and/ or AB109 Team, CalWORKs, or Drug Court.

d. Drug Medi-Cal
Effective January 1, 2014, Drug Medi-Cal Rates shall be established subsequent to the agreement and shall be communicated to Contractor through an administrative memorandum that will serve as an amendment to the agreement.

Drug Medi-Cal(DMC) certified substance abuse clinics shall be limited to the following modalities of treatment services as described in Title 22, California Code of Regulations (CCR), Section 51341.1: DMC Perinatal services shall be certified in accordance with DMC Periantal regulations.

i. Outpatient Drug Free Treatment- outpatient service directed at stabilizing and rehabilitating persons with Substance Use Disorder diagnoses.

ii. Day Care Rehabilitative Treatment means outpatient counseling and rehabilitation services provided at least three (3) hours per day, three (3) days per week to persons with Substance Use Disorder diagnoses, who are pregnant or in the postpartum period, and/or to Early and Periodic Screening Diagnosis, and Treatment (EPSDT)-eligible beneficiaries. For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than 10 clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

e. Urine Analysis Testing
Urine Analysis (UA) Testing is used as a therapeutic intervention and as a tool 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 the client treatment plan should be adjusted.

f. Transportation
The arrangement for, or the transportation of, a client to and from treatment services.

B. Fixed Rate Services

1. NRC Outpatient Treatment

2. County Day Treatment

3. County Funded Outpatient

4. Mental Health Services Act Co-Occurring

5. CalWorks Day Treatment

6. CalWorks Individual and Family Therapy

C. Fee For Service

1. Drug Court Funded Services

   a. Outpatient Treatment Services

   b. Day Treatment

   c. Drug Testing

   e. Sober Living Environment (SLE)

   f. Residential

   g. NRT MMT, MMD and MAT

   h. Individual and Family Therapy

   i. Short Doyle Medi-Cal

2. Achieve 180 Re-Entry Services (January 1, 2014 – March 31, 2014)

   a. Outpatient Treatment Services

3. Criminal Justice Realignment

   Contractor will provide authorized services to individuals meeting the Criminal Justice Realignment (CJR) eligibility criteria as determined by AB 109 and AB 117 and referred by the CJR program.

   Substance use disorder (SUD) treatment shall be provided to eligible offenders based on treatment need with available funding resources. A full continuum of SUD treatment services are available to CJR clients based on assessed treatment need.

   a. Outpatient Treatment Services

   b. Day Treatment Services

   c. UA's

   d. Individual and Family Therapy

4. Drug Medi-Cal Services

   Contractor shall provide DMC services in compliance with DHCS requirements pending final approval of Centers for Medicare and Medicaid and the State Department Alcohol abd Drug Services.

5. Mental Health Clinic – Women's Enrichment Center

Contractor will provide the following mental health services in accordance with the requirements of the BHRS Documentation Handbook including additions and revisions, incorporated by reference herein. All services will be documented using Medi-Cal documentation rules.

a. Mental Health gender specific co-occurring services will be provided by Women's Enrichment Center. Women's Enrichment Center provides trauma informed co-occurring services for clients with Mental Health and Substance Abuse conditions. Expected complex conditions of clients referred for treatment: severe emotional disorders, history of trauma, domestic violence, substance abuse, employment issues, treatment compliance issues, and medical issues.

b. Contractor will give priority admission to individuals who are referred by CalWORKS. The length of treatment may vary according to the specific need of each program participant however the services will typically last at least twelve (12) weeks. Contractor will provide the following services at mutually agreed upon location(s) in San Mateo County to individuals meeting eligibility criteria for Mental Health services.

c. Contractor will make services available a minimum of four (4) days per week. Mental health services including, but not limited to group services will be provided. Clients may also attend psycho educational groups that address their substance use disorders. Groups with a primary focus on substance use will not be billed to Short Doyle Medi-Cal. Other mental health services and case management brokerage will be made available as needed.

d. Contractor will provide the following intensive outpatient treatment services for program participants with co-occurring disorders, determined by medical need.

e. Intake and assessment, plan development, rehabilitation, group rehabilitation, therapy, group therapy, family therapy and collateral services:

i. Assessment: Document the clinical analysis of the client's current mental, emotional or behavioral condition. The assessment is designed to provide a current, accurate, functional diagnosis which will be utilized to develop a comprehensive interactive treatment plan with appropriate goals and interventions.

ii. Plan Development: Development of strength based plans with the client and monitored throughout the clients treatment. The client will be involved in the setting of goals and subsequent review of their progress.

iii. Individual Therapy: Interventions will be included which primarily focus on symptom reduction as a means to improve functional capabilities and support client goal achievement. All therapeutic interventions will be strength –based, holistic, trauma informed and culturally sensitive.

iv. Group Therapy: Therapeutic interventions offered to more than one client in a group setting. These groups may include but are not limited to: psychosocial rehabilitation, therapy, and symptom reduction.

v. Collateral Services: Provides contact with any significant support person in the client's life. Services may include, but is not limited to family members and others identified by the client. All contacts will focus on the client's issues and needs. Collateral services include helping the significant support persons to understand and accept the client's condition and involve them in the service planning and implementation of the service plan

vi. Family Therapy: May be used when a client and one or more family members are present. The focus of this therapy is on the care and management of the client's mental health symptoms within the family dynamic.

vii. Rehabilitation Services: This service may be delivered by any clinical staff member to a client and/or the client's family, or to a group of clients. Rehabilitation services include assistance in improving, maintaining, or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/ or medication compliance. It also includes counseling of the client and/ or client's family including psychosocial education aimed at helping achieve the client's goals, and includes monitoring of medication compliance by non-medical staff.

viii. Crisis Intervention: When medically necessary, these services will be provided to or on behalf of a client. Such services are for conditions that, if left untreated present an imminent threat to the client or others. Crisis intervention is a service lasting less than twenty-four (24) hours. These services may include but are not limited to: assessment, collateral and therapy to address the immediate crisis.

ix. Targeted Case Management: Service activities focus on client needs and strengths and assist a client to access needed medical, educational, social, prevocational, and rehabilitative or other needed community services. Case Management services may include but are not limited to the following:

1) Linkage and Coordination: Identification and pursuit of resources through interagency collaboration, monitoring of service delivery, and brokering necessary services.

2) Placement services supportive assistance to the individual in the assessment, determination of need, and securing of adequate and appropriate living arrangements including but not limited to locating and securing an appropriate living environment, locating and securing funding, pre-placement visit(s), placement and placement follow-up, accessing services necessary to secure placement.

E. Description of Unique Program Services

1. Archway

Archway provides outpatient substance abuse treatment and recovery services to clients who are participating in Proposition 36 and are referred by the Probation or Parole Departments, and to clients mandated to complete one of the following: Wet & Reckless, First Offender Program, Anger Management, Deferred Entry of Judgment, or Domestic Non-Violence Program. Services are available to clients in English and Spanish. Archway's outpatient program is a minimum of twelve (12) weeks. Clients attend weekly group and individual sessions, and are required to complete a minimum of six (6) community support meetings.

2. First Chance Outpatient Services

First Chance Outpatient Services (FCOS) provides outpatient substance abuse treatment, recovery and mental health and recovery services to clients participating in Proposition 36 or Drug Court, and who are referred by Probation, Parole, or AOD. FCOS program is a minimum of twelve (12) weeks and is designed for clients with co-occurring mental health and substance abuse disorders. The number of required individual and group sessions are customized according to the client's individual need. The program uses a harm reduction model while challenging clients to attain sobriety.

3. Insights

Insights provides outpatient substance abuse treatment and recovery services to adolescent clients and their families. The program is a minimum of eight (8) weeks, but is often extended based upon client need. Services include family assessments, adolescent assessments, family education groups, group counseling, individual counseling, and family counseling sessions and mental health services. All services are provided on-site.

4. Girls Program

The GIRLS Program is a court-mandated outpatient substance abuse treatment recovery and mental health program that provides assessment, counseling and case management services for adolescent girls aged thirteen (13) through eighteen (18) with co-occurring substance abuse and mental health disorders. Services include family assessments, adolescent assessments, family education groups, group counseling, individual counseling, and in-home family counseling sessions.

5. Camp Glenwood

Camp Glenwood services include weekly psycho-educational and group counseling services to adolescent boys incarcerated at Camp Glenwood.

6. Women's Enrichment Center

The Women's Enrichment Center (WEC) provides intensive day substance abuse treatment and recovery mental health services to adult women with co-occurring substance abuse and mental health disorders. Clients are either referred by or eligible for services from CalWORKs and/or Children and Family Services. WEC coordinates with SMC, BHRS and other providers to ensure ongoing planning, coordination and services that address the needs of WEC clients. The program is a minimum of ten (10) weeks. The length of time any individual participant is in the program is based upon the client's need. Clients attend treatment five (5) days a week for three (3) hours per day, and receive: intensive case management services, group counseling, weekly individual counseling, psycho-educational group classes, supportive services such as transportation to and from treatment, light breakfast and lunch.

7. First Chance Sobering Station

First Chance Sobering Station provides a sobering facility that operates twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days of the year. This facility provides temporary shelter, individualized substance abuse/dependence assessment, observation, recovery counseling and referral services for ongoing treatment, and twelve (12)-Step meetings for all individuals admitted to the facility.

First Chance Sobering Station services are available to individuals referred by participating law enforcement agencies, San Mateo County Health Services, and partnering substance abuse treatment and recovery agencies providing residential and intensive day treatment services. Partnering agencies may access the First Chance Sobering Station services for clients in need of a temporary safe shelter until the client sobers up and is able to be admitted or re-admitted into treatment. To access services, the partnering agency will transport the client to the First Chance Sobering Station and remain present with the client until admitted into the Sobering Station, in accordance with the StarVista - First Chance Sobering Station Program Policy.

8. Non-Reimbursable Services

a. Driving Under The Influence (DUI)
In accordance with the AOD Provider Handbook, Contractor will provide the DUI program services to clients who have been referred by the Department of Motor Vehicles, Probation, and the Superior Courts.

b. Deferred Entry of Judgment (DEJ)

In accordance with the AOD Provider Handbook, Contractor will provide the DEJ to clients who have been referred by the Probation Department.

9. Wec Co-Occurring Mental Health Services

Mental Health Gender Specific Co-Occurring services will be provided by StarVista through the Women's Enrichment Center Mental Health Clinic. Women's Enrichment Center provides trauma informed co-occurring services for clients dealing with Mental Health and Substance Abuse conditions. Expected complex conditions of clients referred for treatment are severe emotional dysregulation, history of trauma, domestic violence, substance abuse, unstable housing, employment issues, treatment compliance issues, and medical issues.

Contractor will admit individuals, who are referred by BHRS. The length of treatment may vary according to the specific need of each program participant however the services will typically last at least ten (10) weeks. Contractor will provide the following services at mutually agreed upon location(s) in San Mateo County to individuals who are deemed eligible for Mental Health funded services.

a. Contractor will make services available five (5) days per week. Mental health services will be provided five (5) days a week to Mental Health Clients in the morning. In the afternoon, the women with co-occurring conditions have the option of participating in substance abuse treatment.

b. Contractor's intensive outpatient treatment services for program participants with co-occurring disorders will provide the following services, determined by medical need, to program participants:
   i. Intake and assessment, plan development, rehabilitation, group rehabilitation, therapy, group therapy, family therapy and collateral therapy.

II. PRIORITY POPULATIONS

Contract funds must be used to serve priority population clients. Specifically, Contractor will give priority admission to:

A. Populations required by Substance Abuse Prevention and Treatment (SAPT) Block Grant:
   1. Pregnant females who use drugs by injection
   2. Pregnant females who use substances
   3. Other persons who use drugs by injection

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

B. San Mateo County residents who are referred by County Behavioral Health and Recovery Services (BHRS);

C. Referrals from other San Mateo County BHRS providers and Shelter referrals within San Mateo County.

III. ADMINISTRATIVE REQUIREMENTS

In providing its services and operations, Contractor will maintain compliance with requirements of the AOD Provider Handbook, including additions and revision, which is incorporated by reference herein.

A. SUD Services under the Affordable Care Act

Effective January 1, 2014, most residents will have health coverage either through Medi-Cal, or through an Other Health Care (OHC) provider. OHC coverage may be through the health care exchange marketplace or through employer based plans.

1. To maximize revenues and increase access to SUD treatment services, Contractor shall:

a. Screen all potential clients for health coverage;

b. Bill all eligible OHC payors financially responsible for a beneficiary's health care services;

c. Verify health coverage for all individuals seeking services. Coverage may be verified on the https://www.medi-cal.ca.gov/Eligibility/Login.asp .

2. Uninsured Residents seeking SUD Services

a. Contractor may provide and bill County or NRC funds to provide needed SUD services to low income residents who are uninsured using an approved sliding scale fee. Contractor shall make a good faith effort to facilitate client enrollment into health coverage, if client is likely eligible for coverage.

b. Once health coverage is obtained by the client, Contractor shall:

i. Medical Beneficiaries: provide and bill Drug Medi-Cal (DMC) for client services provided to Medi-Cal beneficiaries or transition client to DMC certified provider within 30 days coverage; or

ii. Other Health Care (OHC) Beneficiaries: provide and bill OHC provider for service, or transition client to OHC provider within 30 days of coverage.

3. Medi-Cal Beneficiaries Seeking SUD Services

a. Contractor shall bill Drug Medi-Cal (DMC) for services provided to Medi-Cal beneficiaries, if providing a service covered by DMC.

b. If client has Other Health Coverage (OHS) in addition to Medi-Cal, Contractor must follow process established under ADP Bulletin 11-01 including future DHCS updates regarding the processes Drug Med-Cal claims for clients with OHC.

c. Contractor may provide services to Medi-Cal beneficiaries and bill County or NRC funds for services when the following Certification and Program requirements have been met:

4. Drug Medi-Cal Certification

Contractor shall submit DMC certification application to the DHCS. If the following conditions are met, Contractor may use County or NRC funding to provide services to Medi-Cal clients until DMC Certification is obtained.

a. Original DMC benefit: Contractor must submit DMC certification application prior to January 1, 2014.

b. Expanded benefit (effective January 1, 2014): Contractor must submit DMC certification application forty-five (45) days after the DHCS release of the revised DMC certification application, or by January 1, 2014, whichever date is later.

c. Once DMC Certification has been received, all Medi-Cal beneficiary services must be billed to the DMC program for reimbursement.

d. Contractor is ineligible for DMC certification for one of the following reasons:

i. zoning restrictions, and/or

ii. IMD exclusion, and/or

iii. program services are not covered by the DMC benefit.

e. Program and Client Requirements

i. The beneficiary has an indicated need for service, and

1) The indicated service is not covered by DMC. This may include residential detoxification, room and board for residential treatment, and targeted case management for outpatient treatment, or

2) The Contractor is providing services to meet unique client need which cannot be met by a DMC provider, such as language, or accessibility

B. OHC Beneficiaries Seeking SUD Services

1. SMC SUD Contractors are encouraged but not required become SUD providers under the Covered California exchange/marketplace and with the existing OHC plans.

2. Contractor shall bill all eligible OHC payors financially responsible for a beneficiary's health care services.

3. Individuals with OHC shall be referred to OHC provider network, if Contractor is not an OHC provider.

4. Anytime a client begins coverage under an OHC plan, Contractor has thirty (30) days to transition client to OHC provider and/or become an OHC provider.

5. When the client's OHC does not offer SUD Treatment Service and/or indicated level of care, Contractor may provide the service and bill County or NRC sources, if the following conditions have been met:
   a. Prior Authorization for the service must be requested and granted by BHRS Call Center.
   b. Contractor must follow established BHRS policies and procedures to receive County or NRC payment for services provided to OHC beneficiaries.

C. System-Wide Improvements

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

1. Community Service Areas (CSA)

   a. BHRS is redesigning the service delivery system to improve quality and access of clients to services. BHRS services will be divided in to six geographic community service areas.

   b. Contractor will participate in activities to improve partnership and service delivery within the CSA that the contractor is located.

2. Standards of Care

   The County has identified specific Standards of Care (SOC) for treatment services, which incorporate scientific research, and clinical practice, which has been proven effective in the provision of services to clients receiving treatment services. SOC are guidelines for providing comprehensive, client centered, culturally competent screening, assessment and treatment for clients with substance abuse and/or substance dependence/addiction or co-occurring disorders.

   In providing its services and operations, Contractor will maintain full compliance with SOC requirements and have a process to evaluate compliance and quality of implementation of each standard.

3. Complex Clients and Co-occurring Disorders

   a. Contractor will participate as a Change Agent and will delegate participation in monthly activities to effect the changes necessary to maintain and enhance COD capability.

   b. Contractor shall establish a COD work plan to assess and address the needs of complex clients. This COD work plan may be a part of the Contractor's Quality Improvement program, Standards of Care implementation plan, or it may be a separate process.

   c. Contractor shall report quarterly to the assigned AOD Analyst on the progress and outcomes of the COD work plan.

   d. Contractors receiving MHSA funding to treat clients with COD shall comply with additional reporting requirements as outlined in the online AOD Provider Handbook.

4. Quality Improvement

   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 Standards of Care, co-occurring and complex client capability, and client feedback.

c. Contractor shall have established 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.

d. Annual QI Plan

i. Contractor shall develop and implement an annual Quality Improvement Plan which addresses quality, policy, and process improvement needs identified by QI committee.

ii. Contractor annual QI plan is due to the assigned AOD Analyst no later than September 1 of the contract year.

iii. Contractor shall report quarterly to the assigned AOD Analyst on QI plan status, progress and client feedback results.

5. Client Feedback

Contractor will solicit feedback from service recipients on an annual basis, at minimum. Client feedback process may include, but is not limited to: focus groups and client satisfaction surveys. Consideration of client feedback will be incorporated into future QI plans.

D. Qualified Service Organization

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

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. Education, training and technical assistance as needed.

6. In addition BHRS will:

   a. Acknowledge that in receiving, storing, processing, or otherwise using any information from the alcohol/drug program about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;

   b. 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

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

E. AVATAR Electronic Health Record

Contractor will work collaboratively with BHRS in the use of the electronic health record system by:

a. Contractor shall enter client service data into Avatar for service being provided under County contract that includes: date of service, service type, service units and service duration.

b. Contractor will maintain compliance with all documentation, reporting, billing and all other data requirements as required in the BHRS and the AOD Provider Handbook, including additions and revisions.

c. Contractor shall enter client wait list data into Avatar. This information will be used to determine unmet treatment needs and wait times to enter treatment.

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

F. Building Capacity

The County seeks to build capacity and increase access to treatment services for San Mateo County residents. Contractor will work with BHRS to maximize the revenues and increase access to care in the following ways:

1. Medi-Cal

Contractor will work in partnership with BHRS to provide substance use disorder treatment services to beneficiaries of Medi-Cal. All services will be delivered in compliance with Drug Medi-Cal Certification requirements and BHRS Policy and Procedures found in the AOD Provider Handbook.

2. Other Revenue Enhancement

Contractor will work in conjunction with AOD to assess whether contracted agency is ready to expand services to other Medi-Cal funded services or other new revenue opportunities.

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 650-573-2714 or jafrica@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 Program Manager and the Health Equity Initiatives Manager (HEIM) by September 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;

   b. Contractor forum for discussing relevant and appropriate cultural competence-related issues; (such as a cultural competence committee);

   c. Collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation;

   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 with clients in a culturally and linguistically appropriate manner);

   e. Staff training plan related to cultural competency. Contractor will ensure that all program staff receives 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.

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 for the term of the Agreement. Contractor shall submit to BHRS ODE by March 31st, a list of staff who have participated in these efforts. For more information about the Cultural Competence Council (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, the contractor is expected to contact Access Call Center or their BHRS 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. Technical Assistance

   Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the Program Manager and HEIM (jafrica@smcgov.org) to plan for appropriate technical assistance.

H. Certification and Licensing

A program providing services to San Mateo County residents must 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, Drug Medi-Cal, Short-Doyle Medi-Cal, Medi-Cal/Medicare.

I. Ineligible Employees

BHRS requires that contractors identify the eligibility status of employees, interns or volunteers prior to hiring and on an annual basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting form, Policy #93-11) should a current employee, intern or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns and volunteers by using the following websites:

1. Office of Inspector General

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

2. Department of Health Care Services

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

Contractor shall submit verification of the ineligible screening process on January 2nd of each contract year.

J. Advance Directives

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

K. Administering Satisfaction Surveys

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

L. Client Rights

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

Contractor shall comply with the California Department of Health Care Services requirements relating to client rights. Contractor shall include the following in Contractor's Policy and Procedures:

1. statement of non-discrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay
2. client rights;
3. grievance procedures;
4. appeal process for discharge;
5. program rules and regulations;
6. client fees;
7. access to treatment files in accordance with DHCS Executive Order #B-22/76
8. copy of the document shall be provided to each client upon admission or posted in a prominent place, accessible to clients

M. Retention of Records

Paragraph 13 ("Retention of Records") of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary records (including medical and/or clinical records) for a period of seven (7) years, except that the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until one (1) year beyond the person's eighteenth (18^{th}) birthday or b) for a period of seven (7) years beyond the date of discharge, whichever is later.

N. Licensing and Certification Report

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

O. Fingerprint Compliance

At County's sole discretion, Contractor certifies that its employees and/or its subcontractors, assignees, and volunteers who, during the course of performing services under this Agreement, have contact with children or any person under his or her care will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of children or individuals with whom Contractor's employees and/or its subcontractors, assignees, or volunteers have contact. If said employees and/or subcontractors, assignees, and volunteers have such a criminal history, they shall not have contact with children who receive services through this agreement. Fingerprint information received from the Department of Justice (DOJ) shall be retained or disposed of pursuant to DOJ directive.

P. Documentation of Services

Contractor shall provide all pertinent documentation required for local, state and federal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). Documentation shall be completed in compliance with the BHRS Policies & Documentation Manual (as defined in Paragraph II. of this Exhibit A) located online at: http://smchealth.org/SOCMHContractors, and is incorporated by reference herein.

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

Q. 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 Behavioral Health Plan, if the Contractor serves only Medi-Cal clients.

R. Credentialing

Contractor is responsible for implementing a process to verify, at time of employment, the credentials of its clinical and/or certified counseling staff (or obtain a waiver). All clinical and/or certified counseling personnel must comply with HIPAA regulations to obtain a National Provider Identifier (NPI) number. The license and NPI information shall be reported to the County through the completion of a County provided credentialing form and submitted to the BHRS Quality Management team. Thereafter, on a yearly basis, Contractor is responsible to conduct a re-credentialing check verifying the NPI number, and ensure that qualification standards have been met and all applicable licenses are current. Verification of credentialing shall be submitted to the BHRS AOD analyst on January 2 of each contract year and/or as requested.

S. Staff Termination

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

T. 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.

U. Compliance Plan and Code of Conduct

Contractor shall read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct located at : http://smchealth.org/sites/default/files/Compliance-CodeofConductfinal.pdf. In addition, Contractor shall assure that Contractor's workforce is aware of compliance mandates, and are informed of the existence and how to use the Compliance Improvement Hotline Telephone Number (650) 573-2695.

IV. GOAL AND OBJECTIVE

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

Goal: Increase the percentage of program participants with a successful treatment discharge

Objective:	Contractor shall increase the percentage of successful treatment discharges from 59% to 61%. Successful treatment discharge occurs when a program participant completes his/her treatment/recovery plan or is transferred for continued treatment.

END OF EXHIBIT A

EXHIBIT B–2-1
BHRS – ALCOHOL AND OTHER DRUG SERVICES
STAR VISTA
JULY 1, 2012 – DECEMBER 31, 2013

In full consideration of the services provided by Contractor in Exhibit A-2-1, County shall pay Contractor based on the following fee schedule:

I. ALCOHOL AND DRUG TREATMENT AND RECOVERY SERVICES

In full consideration of the services provided by Contractor and subject to the provisions of Paragraph 3. ("Payments") of this Agreement, County shall pay Contractor in the manner described below, except that any and all payments shall be subject to the conditions contained in this Agreement. Contractor shall receive monthly payments as outlined below, upon timely submission of reports as outlined in the AOD Provider Handbook.

A. 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 on page 1 of this Agreement. Furthermore, of the total contract obligation, County shall not pay or be obligated to pay more than SIX MILLION EIGHT HUNDRED SEVENTY-THREE THOUSAND NINE HUNDRED FIFTY-FOUR DOLLARS ($6,873,954).

B. Fixed Rate Payments

For the term July 1, 2012 through June 30, 2013, Contractor shall be paid in twelve (12) monthly payments of SEVENTY-ONE THOUSAND SIXTY DOLLARS ($71,060).

July 1, 2012 – June 30, 2013

Services	Funding Amount	Monthly Funding Amount	Rate	Units Of Service per FY	# clients to be served	Slots
NRC Insights Outpatient Treatment	$147,086	$12,257	$45.50	3232	40	8
Insights County Funded OP	$23,624	$1,969	$45.50	1075	11	3
Camp Glenwood	$44,133	$3,678	$45.50	970	10	3
MHSA GIRLS Program	$88,000	$7,333	$45.50	1934	6	2
MHSA GIRLS/COD	$46,289	$3,857	$45.50	1017	4	1
Cal WORKS WEC	$181,541	$15,128	$185.50	979	19	4
Sobering Station	$278,349	N/A	$37.43	7436		
Adolescent						

Outpatient	$29,613	$2,468	$37.43	791		
MCE OP Match	$292,430	$24,370				
TOTAL	$1,131,065	$71,060				

For the term July 1, 2013 through December 31, 2013, Contractor shall be paid in twelve (12) monthly payments of SEVENTY-ONE THOUSAND SIXTY DOLLARS ($71,060).

July 1, 2013 – December 31, 2013

Services	Funding Amount	Monthly Funding Amount	Rate	Units Of Service per FY	# clients to be served	Slots
NRC Insights Outpatient Treatment	$73,543	$12,257	$45.50	1616	20	4
Insights County Funded OP	$11,812	$1,969	$45.50	537	5	1
Camp Glenwood	$22,066	$3,678	$45.50	485	5	1
MHSA GIRLS Program	$44,000	$7,333	$45.50	967	3	1
MHSA GIRLS/COD	$23,145	$3,857	$45.50	509	2	1
Cal WORKS WEC	$90,770	$15,128	$185.50	489	10	2
Sobering Station	$139,175	N/A	$37.43	3718		
Adolescent Outpatient	$14,806	$2,468	$37.43	395		
MCE OP Match	$146,215	$24,370				
TOTAL	$565,532	$71,060				

CalWORKs

Any reduction to the CalWORKs Mental Health Substance Abuse Allocation will result in a reduction in the Contractor's funding maximum by the amount of the CalWORKs reduction. Any such funding reduction shall first be taken from the county funding.

1. Reporting Requirements and Outcomes Data Collection for Clients Funded by CalWORKs

   Contractor shall collect the following information and report it on a monthly basis: the client's name, DOB, DAISY ID#, CalWORKs/CalWIN#, Medi-Cal/BIC# (if applicable), case worker name, admission date, discharge date, the number of visit days, staff hours including individuals and group visits, and the referring agency.

2. Contractor shall collect the following outcomes data on each client exiting treatment, and report on a quarterly basis:

i. Employment status
ii. Housing status
iii. Status of current alcohol or other drug use.

The maximum fixed rate amount County shall be obligated to pay for services rendered under this Agreement shall not exceed ONE MILLION SIX HUNDRED NINETY-SIX THOUSAND FIVE HUNDRED NINETY-SEVEN DOLLARS ($1,696,597). Contractor shall be paid in thirty monthly payments of SEVENTY-ONE THOUSAND SIXTY DOLLARS ($71,060).

C. MCE Match and Federal Financial Participation

1. MCE Rates

MCE service reimbursement requires unmatched local or state funding to match federal funds. This funding has been identified as "MCE County Match" within this Agreement. Federal reimbursement fifty percent (50%) is the current published Federal Financial Participation (FFP) percentage. Rates for FY 2012-13 shall be established subsequent to the Agreement and shall be communicated to Contractor through an administrative memorandum that will be an attachment to the Agreement.

2. MCE Maximum

MCE services described in Exhibit A-2-1, Section I.B.3 shall be funded by County match fifty percent (50%) and FFP fifty percent (50%). The fifty percent (50%) County match is included in the fixed rate payments. The FFP shall be paid on a fee-for-service format based upon monthly invoices provided by the Contractor.

The FFP maximum for the period July 1, 2012 through June 30, 2013, shall not exceed TWO HUNDRED NINETY-TWO THOUSAND FOUR HUNDRED THIRTY DOLLARS ($292,430).

July 1, 2012 – June 30, 2013

Service	Unit Rate
County Funded Match	$292,430
Federal Financial Participation (FFP)	$292,430
TOTAL MCE SERVICE FUNDING	$584,860

The FFP maximum for the period July 1, 2013 through December 31, 2013, shall not exceed TWO HUNDRED NINETY-TWO THOUSAND FOUR HUNDRED THIRTY DOLLARS ($292,430).

July 1, 2013 – December 31, 2013

Service	Unit Rate
County Funded Match	$146,215
Federal Financial Participation (FFP)	$146,215
TOTAL MCE SERVICE FUNDING	$292,430

The maximum payment for MCE services, including both the County match and the FFP, shall not exceed EIGHT HUNDRED SEVENTY-SEVEN THOUSAND TWO HUNDRED NINETY DOLLARS ($877,290).

3. MCE Reporting and Reconciliation

Contractor will provide quarterly reports using County approved service reporting form(s) completed by Contractor or by using County provided service reporting form(s). The reports shall include the following:

1. Total units of service
2. Services delivered

Contractor shall submit to County a year-end billing report no later than ninety (90) days after the end of each fiscal year (June 30th). This report will include a final determination of eligibility for MCE services and will be the basis for an annual reconciliation.

Reports and invoices shall be sent to:
AOD Program Analyst
400 Harbor Blvd, Building E
Belmont, CA 94002

If the final reconciliation shows that an MCE payment was made for services for which eligibility was not in place, Contractor shall reimburse County the FFP portion of the MCE payment(s).

If the final reconciliation shows that services were provided to MCE eligible clients for which MCE payment was not made, County shall pay Contractor for services delivered at the MCE rate included herein. In any case, the maximum payment shall not exceed the Agreement maximum as established in Paragraph I.A. of this Exhibit B-2-1.

4. Billing

MCE services will be billed and reimbursed in accordance with the AOD Provider Handbook and the BHRS Documentation Handbook.

County funded MCE match is paid on a fixed rate basis and will be reconciled to the actual service billed on a quarterly basis. Federal Financial Participation (FFP) reimbursement rates are based on the established MCE rates. County funding is required to meet local FFP match requirements. In the event that Contractor fails to meet contractual obligations in MCE service delivery and billing, BHRS may suspend or withhold payment. In the event that Contractor exceeds billing target, an amendment will be required to identify funds for County match requirement and to increase FFP revenues. Service specific reimbursement rates for FY11/12 are pending approval of San Mateo County's Low Income Health Program application and, upon approval, shall be communicated to Contractor through an administrative memorandum that will serve as an amendment to the agreement.

5. MCE Disallowances

County and Contractor agree that in the event that any MCE services provided by Contractor are disallowed for MCE reimbursement due to: 1) Contractor's failure to provide documentation adequate to support Contractor's services per the AOD Provider Handbook and the BHRS Documentation Manual; 2) Client being ineligible for MCE reimbursement; and/or 3) Contractor's failure to obtain prior authorization for MCE services from the BHRS Access Call Center; then subsequent MCE payments shall be reduced by the amount of the FFP paid for disallowed services, or Contractor shall reimburse the County.

Disallowances that are attributable to an error or omission on the part of County shall be the responsibility of County.

D. Variable Rate /Fee For Service

For the term July 1, 2012 through June 30, 2013, the County's total fiscal obligation for the aggregate amount allocated between all Contactors who provide the same or similar services shall not exceed FIVE HUNDRED SEVENTY-FIVE THOUSAND THREE HUNDRED EIGHTY-EIGHT DOLLARS ($575,388)

July 1, 2012 through June 30, 2013

Funding Source	Service	Unit Rate
Drug Court and Cal-EMA Grant Funded Services*	Individual / Group Session	$ 50.00 Per Staff Hour
	Day Treatment	$120.00 Per Day
	Aftercare	$ 40.00 Per Hour

	Drug Testing	$ 30.00 Per Screen
Ryan White	Outpatient	$ 50.00 Per SAH
	Day Treatment	$ 120.00 Per Day
Achieve 180	Outpatient Tx	$ 50.00 Per SAH
	Day Treatment	$120.00 Per Day

* Cal-EMA funding ends June 30, 2013.

For the term July 1, 2013 through December 31, 2013, the County's total fiscal obligation for the aggregate amount allocated between all Contactors who provide the same or similar services shall not exceed TWO HUNDRED THIRTY-FOUR THOUSAND THREE HUNDRED THIRTEEN DOLLARS ($234,313).

July 1, 2013 – December 31, 2013

Funding Source	Service	Unit Rate
Drug Court and 11550 Funded Services	Individual / Group Session	$ 50.00 Per Staff Hour
	Day Treatment	$120.00 Per Day
	Aftercare	$ 40.00 Per Hour
	Drug Testing	$ 30.00 Per Screen
	Individual & Family Therapy	$2.61 per minute
Ryan White	Outpatient	$ 50.00 Per SAH
	Day Treatment	$ 120.00 Per Day
Achieve 180	Outpatient Tx	$ 50.00 Per SAH
	Day Treatment	$120.00 Per Day

1. Drug Court and 11550 Funded Services

   a. Outpatient Treatment Services
      i. One (1) hour individual and/or group counseling session provided for CDCI/DCP funded outpatient alcohol and drug treatment and recovery services.
      ii. Day Treatment Services per individual for each visit day provided for CDCI/DCP funded alcohol and drug day treatment and recovery services.
      iii. Aftercare Treatment Services per individual for each one (1) hour group counseling session provided for CDCI/DCP funded aftercare alcohol and drug treatment and recovery services.

   b. Drug Testing
      The rate will not exceed the actual cost of the drug screen, plus an administrative fee as specified in the Contractor's approved Drug Testing Plan.

2. Drug Court, 11550, Ryan White, and Achieve 180 Maximum

   Drug Court, Cal-EMA, Ryan White, and Achieve 180 covered services shall not exceed an aggregated amount of THREE HUNDRED FIFTY-TWO THOUSAND SIX HUNDRED NINETY-EIGHT DOLLARS ($352,698).

3. Criminal Justice Realignment (CJR)

   a. CJR Clients with MCE Coverage

      For all CJR clients who are also MCE beneficiaries, payment for services shall be through the MCE benefit. Designated CJR funding shall provide the required local match to draw down FFP funding. Reimbursement for services will be on a fee for service basis.

      Rates for CJR clients with MCE coverage are described in paragraph I.C.1 of this Exhibit B-2-1.

   b. CJR Clients without MCE Coverage

      For individuals referred by the CJR who are non-MCE beneficiaries, reimbursement for services shall be on a fee for services. These services shall be reimbursed in full through designated CJR funds.

      Rates for clients who are not eligible for MCE coverage are established in paragraph I.D. of this Exhibit B-2-1.

   c. CJR Maximum

      For the term July 1, 2012 through June 30, 2013 the County's total fiscal obligation for CJR services, including both the County match and the FFP for MCE services, and CJR funding for non-MCE covered services shall not exceed an aggregated amount of TWO HUNDRED SEVENTY-EIGHT THOUSAND EIGHT HUNDRED SEVENTY-SEVEN DOLLARS ($278,877).

      For the term July 1, 2013 through December 31, 2013 the County's total fiscal obligation for CJR services, including both the County match and the FFP for MCE services, and CJR funding for non-MCE covered services shall not exceed an aggregated amount of ONE HUNDRED THIRTY-NINE THOUSAND FOUR HUNDRED THIRTY-EIGHT DOLLARS ($139,438).

The maximum payment for alcohol and drug treatment services and criminal justice realignment shall not exceed an aggregate amount of ONE MILLION TWO HUNDRED TWENTY-EIGHT THOUSAND SIXTEEN DOLLARS ($1,228,016).

E. Non-Reimbursable Services

In accordance with the AOD Provider Handbook, DUI/DEJ services are a non-reimbursable service. DUI/DEJ administrative fees must be approved by the County Health System Chief.

1. First Offender Programs

Contractor shall remit monthly to the County Alcohol and Other Drug Services Administrator a eight percent (8%) administrative fee for FOP of the gross revenues received, less refunds to participants, amount of any participant checks returned for insufficient funds, fees charged to Contractor for returned checks, and State administrative fees for the FOP.

2. Deferred Entry of Judgment

Contractor shall remit monthly to the County Alcohol and Other Drug Services Administrator a five percent (5%) administrative fee of the gross revenues received, less refunds to participants, amount of any participant checks returned for insufficient funds, fees charged to Contractor for returned checks, and collections for drug testing for the DEJ program.

F. In any event, the maximum amount County shall be obligated to pay for services rendered under Exhibit A-2-1 of this Agreement shall not exceed THREE MILLION THREE HUNDRED SIXTY-THREE THOUSAND TWO HUNDRED FIFTY-EIGHT DOLLARS ($3,363,258) for the term of the Agreement.

G. Required Fiscal Documentation

1. Contractor's annual budget, and line item narrative justification covering all contracted services under this Agreement is subject to review and approval by the San Mateo County AOD program liaison for each fiscal year.

2. Contractor will comply with all fiscal and reporting requirements for funded services as specified in the AOD Provider Handbook.

H. Monthly Invoice and Reports

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 – AOD Program Analyst
400 Harbor Blvd., Bldg. E
Belmont, CA 94002

The Chief of the Health System 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.

In the event this Agreement is terminated prior to December 31, 2013, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the Chief of the Health System or designee.

I. Modifications to the allocations in Paragraph A of this Exhibit B-2-1 may be approved by the Chief of the Health System or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

J. 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.

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

for specific services may be reduced at the discretion of the Chief of the Health System or designee.

K. 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, and this Agreement may either be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 4 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any

L. 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.

M. Claims/Invoice 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. 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 _____"

EXHIBIT B–2–2 – PAYMENTS AND RATES
STARVISTA
BHRS ALCOHOL AND OTHER DRUG SERVICES
JANUARY 1, 2014 – JUNE 30, 2015

In full consideration of the services provided by Contractor in Exhibit "A", County shall pay Contractor as follows:

I. PAYMENTS

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 ("Payments") 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 Provider Handbook located at:
http://smchealth.org/sites/default/files/docs/BHS/AOD/PaymentandMonitoringProceduresFY13-14.pdf

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 on page 1 of this Agreement. Furthermore, of the total contract obligation, County shall not pay or be obligated to pay more than TEN MILLION THIRTY-NINE THOUSAND THREE HUNDRED THREE DOLLARS ($10,039,303).

In any event, the maximum amount county shall be obligated to pay for AOD services rendered under Exhibit A-2-2 of this Agreement shall not exceed THREE MILLION ONE HUNDRED SIXTY-FIVE THOUSAND THREE HUNDRED FOURTY-NINE DOLLARS ($3,165,349).

B. Fixed Rate Payments

The maximum fixed rate amount County shall be obligated to pay for fixed rate services rendered under this Agreement shall not exceed ONE MILLION SIX HUNDRED TWENTY-ONE THOUSAND FIVE HUNDRED NINETY-EIGHT DOLLARS ($1,621,598). Contractor shall be paid in eighteen (18) monthly payments of SIXTY-SIX THOUSAND EIGHT HUNDRED NINETY-THREE DOLLARS ($66,893).

C. Fee for Service

Service Type	2012-14
Individual Therapy, per session Code **90834**	$88.00
Group Therapy, per person, per session Code **90853**	$29.00
Family Therapy, per hour; includes all members Code **90847**	$90.00
Collateral, per session Code **90887**	$59.00
Clinical Consultation, telephone/15 minutes Code **X8255**	$12.00

c. Expanded Screening/Assessment Services (non-MD)
An assessment shall consist of at least one (1) face-to-face visit and be conducted by a licensed, waivered, or registered mental health professional. The assessment shall include initial phone contact to schedule an intake evaluation; behavior/history checklists mailed to caregiver and teacher; phone consultation with teacher; and review of behavior/history checklists.

Service Type	2012-14
Expanded Screening/Assessment Services, per assessment Code **A8125**	$135.00

d. Psychological Evaluation/Testing Services (Ph.D.)
An evaluation shall consist of individual sessions, scoring of tests, written report and case conference, and classroom observation using structured observation tools. Total time shall be approximately nine (9) hours of service. Services shall be provided by a licensed psychologist. Payment will be made upon receipt of completed psychological evaluation.

Service Type	2012-14
Psychological Testing, per evaluation Code **T9561**	$450.88

2. Girls' Juvenile Court Program

Notwithstanding the method of payment set forth herein, in no event shall County pay or be obligated to pay Contractor more than the sum of ONE HUNDRED THREE THOUSAND TWO HUNDRED FORTY-TWO DOLLARS ($103,242) for services provided under Exhibit A-1-1, Paragraph I.A.2. of this Agreement.

a. Assessment Services (non-MD)

An assessment shall consist of at least one (1) face-to-face visit conducted by a licensed, waivered, or registered mental health professional.

b. Psychological Assessment/Testing Services (Ph.D.)
An evaluation shall consist of individual sessions; scoring of tests; written report and case conference; and classroom observation using structured observation tools; totaling approximately nine (9) hours of service and be conducted by a licensed psychologist. Payment will be made upon receipt of completed psychological assessment.

Psychological Assessment, per evaluation	$450.88

c. Treatment Services
Treatment services shall consist of face-to-face services with client or collateral (except for authorized telephone consultation) and be conducted by a licensed, waivered or registered mental health professional. Rate of payment shall be as follows:

Service Type	**2012-14**
Assessment, per case	$124.00
Psychological Testing Package	$450.88
Individual Therapy, per session	$ 88.00
Group Therapy, per person, per session	$ 29.00
Family Therapy, per hour; includes all members	$ 90.00
Clinical Consultation, telephone per 15 minutes	$ 12.00

3. Child and Family Treatment Collaborative Payment Schedule

Notwithstanding the method of payment set forth herein, in no event shall County pay or be obligated to pay Contractor more than the sum of FIVE HUNDRED FORTY-FOUR THOUSAND DOLLARS ($544,000) for services provided under Exhibit A-1-1, Paragraph I.A.3. of this Agreement.

a. Mental Health Services
For services as described in Paragraph I.A.3.d.4)a) of Exhibit A-1-1 County shall pay Contractor at a rate of ONE DOLLAR AND EIGHTY-THREE CENTS ($1.83) per minute of service, for services that have been documented in the medical record maintained by Contractor to meet documentation requirements of the Medi-Cal program.

b. Crisis Intervention Services

For services as described in Paragraph I.A.3.d.4)b) of Exhibit A-1-1 County shall pay Contractor at a rate of THREE DOLLARS AND EIGHTY-EIGHT CENTS ($3.88) per minute of service, for services that have been documented in the medical record maintained by Contractor to meet documentation requirements of the Medi-Cal program.

c. Case Management Services

For services as described in Paragraph I.A.3.d.4)c) of Exhibit A-1-1 County shall pay Contractor at a rate of TWO DOLLARS AND TWO CENTS ($2.02) per minute of service, for services that have been documented in the medical record maintained by Contractor to meet documentation requirements of the Medi-Cal program.

4. Telephone Hot Line Services

For personnel costs as described in Paragraph I.A.4. of Exhibit A-1-1 County shall pay up to a maximum of TWO HUNDRED TWELVE THOUSAND ONE HUNDRED EIGHTY DOLLARS ($212,180). Payments shall be made for actual costs, and shall be subject to the terms of Paragraph I.B.11. of this Exhibit B-1-1. Payment shall be monthly following invoice by Contractor in the amount of EIGHT THOUSAND EIGHT HUNDRED FORTY DOLLARS AND THIRTY THREE CENTS ($8,840.33).

5. Early Childhood Community Team

Contractor shall receive a maximum of SEVEN HUNDRED THIRTY FOUR THOUSAND SIXTY-FOUR DOLLARS ($734,064) for the implementation of the "Early Childhood Community Team and the 4.33 FTE positions described in A-1-1, E, 3." Unless otherwise authorized by the Chief of the Health System or designee, the rate of monthly payment by the County to Contractor shall be one-twelfth (1/12) of the maximum amount per month, or THIRTY THOUSAND FIVE HUNDRED EIGHTY-SIX DOLLARS ($30,586).

6. Co-Chair of the Diversity and Equity Council

Contractor shall be paid a maximum obligation of TEN THOUSAND DOLLARS ($10,000) for services described in Exhibit A-1-1 Section I. Paragraph F of the Agreement.

7. In any event, the maximum amount County shall be obligated to pay for services rendered under Exhibit A-1-1 Paragraph I.A., of this Agreement shall not exceed TWO MILLION THREE THOUSAND FOUR HUNDRED EIGHTY-SIX DOLLARS ($2,003,486) for the contract term.

8 Monthly Reporting

a. Payment by County to Contractor shall be monthly. Contractor shall bill County on or before the tenth (10^{th}) working day of each month for the prior month. The invoice shall include a summary of services and changes for the month of service. In addition contractor shall provide back-up to the invoice. Such back-up shall be in the form of:
   1) County provided service reporting form(s) ("Service Reporting Form(s)") completed by Contractor according to the instructions accompanying the Service Reporting Form(s), or
   2) County approved form(s) which provide detailed description of services provided including but not limited to: client name, mental health ID#, service date, type of service provided (Ex: TBS, Intensive Day Treatment, etc.), and duration of service (hour/minute format).

b. 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.

9. 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.

10. County May Withhold Payment

Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). Documentation shall be completed in compliance with the County Documentation Manual (as defined in Paragraph I.A of Exhibit A-1-1). The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the Quality Improvement Manager of BHRS of the Health System.

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 the Health System or designee.

12. 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-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 _____"

c. The certification shall attest to the following for each beneficiary with services included in the claim:
   1) An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement.
   2) 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.
   3) The services included in the claim were actually provided to the beneficiary.
   4) 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.
   5) A client plan was developed and maintained for the beneficiary that met all client plan requirements established in this agreement.
   6) 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.
   7) 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 II, B, 10 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 Care 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.

13. Cost Report

a Contractor shall submit to County a year-end cost report no later than ninety (90) days after the expiration date of this Agreement. 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.

b If the annual Cost Report provided to County reveals that total payments to Contractor exceed the total allowable costs for all of the services rendered by Contractor to eligible clients during the reporting period, a single payment in the amount of the difference shall be made to County by Contractor, unless otherwise authorized by the Director of Health or her designee.

14. Where discrepancies between costs and charges are found on the Cost Report to County, Contractor shall make a single payment to County when the total charges exceed the total actual costs for all of the services rendered to eligible patients during the reporting period. Likewise, a single payment shall be made to Contractor by County when the total actual costs exceed the total charges made for all of the services rendered to eligible patients during the reporting period and shall not exceed the total amount in paragraph 3 of this Agreement.

15. 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 the Contractor under this Agreement or any other agreement.

16. 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, and this Agreement may either be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 4 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

17. 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. With every invoice submitted by Contractor to County, 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 each such invoice. The County may withhold payment to Contractor for any and all services for which this required proof of third-party payments and/or denials of such payments is not provided. County may deduct from its payments to Contractor the amount of any such third-party payment. 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.

ii. Contractor shall provide a copy of the completed Payor Financial Form (Attachment D) and in 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 with the first invoice of the Agreement for services provided to said clients.

b. 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 County may withhold payment to Contractor for any and all services pending notification or receipt of such third-party payments or denials of such payments. County may deduct -
party payment. To the extent that County inadvertently makes from its payments to Contractor the amount of any such third payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement.

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 with the first invoice of the Agreement for services provided to say clients.

EXHIBIT B–2–2 – PAYMENTS AND RATES
STARVISTA
BHRS ALCOHOL AND OTHER DRUG SERVICES
JULY 1, 2012 – JUNE 30, 2015

In full consideration of the services provided by Contractor in Exhibit "A", County shall pay Contractor as follows:

I. PAYMENTS

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 ("Payments") 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 Provider Handbook located at:
http://smchealth.org/sites/default/files/docs/BHS/AOD/PaymentandMonitoringProceduresFY13-14.pdf

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 on page 1 of this Agreement. Furthermore, of the total contract obligation, County shall not pay or be obligated to pay more than TEN MILLION THIRTY-NINE THOUSAND THREE HUNDRED THREE DOLLARS ($10,039,303).

In any event, the maximum amount county shall be obligated to pay for AOD services rendered under Exhibit A-2-2 of this Agreement shall not exceed THREE MILLION ONE HUNDRED SIXTY-FIVE THOUSAND THREE HUNDRED FOURTY-NINE DOLLARS ($3,165,349).

B. Fixed Rate Payments

The maximum fixed rate amount County shall be obligated to pay for fixed rate services rendered under this Agreement shall not exceed ONE MILLION SIX HUNDRED TWENTY-ONE THOUSAND FIVE HUNDRED NINETY-EIGHT DOLLARS ($1,621,598). Contractor shall be paid in eighteen (18) monthly payments of SIXTY-SIX THOUSAND EIGHT HUNDRED NINETY-THREE DOLLARS ($66,893).

C. Fee for Service

The maximum payment for alcohol and drug treatment services shall not exceed an aggregate amount of ONE MILLION ONE HUNDRED EIGHT THOUSAND SEVEN HUNDRED FIFTY-ONE DOLLARS ($1,108,751).

D. Fee for Service with Allocation

The maximum payment for fee for service with allocation services shall not exceed an amount of FOUR HUNDRED THIRTY-FIVE THOUSAND DOLLARS ($435,000).

1. Drug MediCal

2. Mental Health Clinic

All Short-Doyle MediCal rates that were in effect FY 2012-13 based on the State Maximum Allowance (SMA), as established by the California Department of Mental Health. Cost Reconciliation will be based upon these FY 2011-12 SMA rates. It is agreed the rate(s) will be changed to the SMA. In no event shall the compensation rate(s) for services under this Agreement exceed the SMA.

The Federal Medical Assistance Percentage medical reimbursable services (FMAP) are used in determining the amount of FFP funds. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAP each year. Services will be reimbursed in accordance with the current published FMAP incorporated by reference herein

a. For the period of January 1, 2014 – June 30, 2014, the maximum amount the County shall be obligated to pay for fee for service with allocation, Short Doyle MediCal, shall not exceed TWENTY-FIVE THOUSAND DOLLARS ($25,000).

b. For the period of July 1, 2014 – June 30, 2015 the maximum amount the County shall be obligated to pay for fee for service with allocation, Short Doyle MediCal, shall not exceed FIFTY-THOUSAND DOLLARS ($50,000).

F. Non-Reimbursable Services

In accordance with the AOD Provider Handbook, DUI/DEJ services are a non-reimbursable service. DUI/DEJ administrative fees must be approved by the County Health System Agency Director.

1. First Offender Program
   Contractor shall remit monthly to the BHRS AOD Administrator a seven percent (7%) administrative fee for First Offender Programs (FOP) of the gross revenues received, less refunds to participants, amount of any participant checks returned for insufficient funds, fees charged to Contractor for returned checks, and State administrative fees for the FOP.

2. Deferred Entry of Judgment
   Contractor shall remit monthly to the BHRS AOD Administrator a five percent (5%) administrative fee of the gross revenues received, less refunds to participants, amount of any participant checks returned for insufficient funds, fees charged to Contractor for returned.

G. Contract Amendments

The Chief of the Health System 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. Modifications

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

I. Ongoing Services

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.

J. Disallowances

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

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. Monthly Invoices 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 – AOD Program Analyst
310 Harbor Blvd., Bldg. E
Belmont, CA 94002

L. County May Withhold Payment

Contractor shall provide all pertinent documentation required for federal Medi-Cal reimbursement (including initial and quarterly notices, assessment and service plans, and progress notes). Documentation shall be completed in compliance with the County Documentation Manual (as defined in Paragraph I.A of Exhibit A). The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the Quality Improvement Manager of BHRS of the Health System. More information regarding payments can be found in the AOD Provider Handbook.

M. Inadequate Performance

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

4 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

N. Early Termination

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

O. Anticipated Change in Revenue

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

P. Documentation

Contractor shall provide all pertinent documentation required for MediCal, 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 disallowed by the DHCS.

Q. Cost Report/Unspent Funds

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 "unspent funds" may be retained by Contractor and expended the following year, provided that these funds are expended for

SUD services approved by County and are retained in accordance with Paragraph V of this Exhibit B.

R. Election of Third Party Billing Process – MediCal participants only

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 Q of this Exhibit B. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.

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

2. Option Two

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

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

S. Beneficiary Billing

Contractor shall accept, as payment in full, the amounts paid by the State in accordance with State Maximum Allowance plus any cost sharing charges (deductible, coinsurance, or copayment) required to be paid by the beneficiary. However, Contractors may not deny services to any DMC beneficiary on account of the beneficiary's inability to pay any or location of eligibility. Contractors shall not demand any additional payment from the County, State, beneficiary, or other third party payers. Contractors shall not hold beneficiaries liable for debts in the event the County or the State becomes insolvent, or for costs of DMC covered services for which the State or County does not pay the Contractor.

T. 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. 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 _____"

END OF EXHIBIT B

SCHEDULE A
STARVISTA
BHRS ALCOHOL AND OTHER DRUG SERVICES
FIXED RATE PAYMENTS

I. FIXED RATE PAYMENTS

January 1, 2014 – June 30, 2014

Services	Funding Amount	Monthly Funding Amount	Rate	Units of Service per FY	Clients to be Served	Slots
NRC Adolescent Outpatient	$73,543	$12,257	$65	1131	6	14
County Funded OP Insights	$11,812	$1,969	$65	182	1	2
Camp Glenwood	$22,067	$3,678	$65	339	2	4
MHSA GIRLS Program	$44,000	$7,333	$65	677	2	1
MHSA GIRLS/COD	$23,145	$3,858	$65	356	1	1
Cal WORKS WEC Day Tx	$90,771	$15,129	$200	454	9	4
Sobering Station	$139,175	N/A	N/A			
Adolescent Outpatient	$14,807	$2,468	$65	228	1	3
County Funded OP	$30,000	$5,000	$65	462	2	5
County Funded Day Tx	$91,215	$15,203	$200	456	9	4
TOTAL	$540,535	$66,893				

July 1, 2014 – June 30, 2015

Services	Funding Amount	Monthly Funding Amount	Rate	Units of Service per FY	Clients to be Served	Slots
NRC Adolescent Outpatient	$147, 086	$12,257	$65	2262	12	14
Insights County Funded OP	$23,624	$1,969	$65	364	2	2
Camp Glenwood	$44,133	$3,678	$65	678	4	4
MHSA GIRLS Program	$88,000	$7,333	$65	1354	4	1
MHSA GIRLS/COD	$46,289	$3,857	$65	712	2	1
Cal WORKS WEC Day Tx	$181,541	$15,128	$200	908	18	4
Sobering Station	$278,349	N/A	N/A			
Adolescent Outpatient	$29,613	$2,468	$65	456	2	3
County Funded OP	$60,000	$5,000	$65	923	4	5
County Funded Day Tx	$182,430	$15,203	$200	912	18	4
TOTAL	$1,081,070	$66,893				

For Outpatient Services only, CalWORKs clients urine analysis will be reimbursed at a rate not to exceed the actual cost of the drug screen, plus an administrative fee as specified in the Contractor's approved Drug Testing Plan.

CalWORKS Modalities and Rates are equivalent to County modalities and rates. Individual & Family Therapy is $2.61 per minute.

SCHEDULE A
STARVISTA
BHRS ALCOHOL AND OTHER DRUG SERVICES
FEE FOR SERVICE WITH ALLOCATION RATE TABLE

I. FEE FOR SERVICE WITH ALLOCATION

January 1, 2014 – June 30, 2014

Funding Source	Service	Unit Rate
Drug MediCal	Outpatient Drug Free Treatment	
	Day Care Rehabilitative Treatment	
Short Doyle MediCal	Assessment	$2.61 per minute
	Plan Development	$2.61 per minute
	Individual Therapy	$2.61 per minute
	Group Therapy	$2.61 per minute
	Collateral Services	$2.61 per minute
	Family Therapy	$2.61 per minute
	Rehabilitation Services	$2.61 per minute
	Crisis Intervention	$3.88 per minute
	Targeted Case Management	$2.02 per minute

July 1, 2014 – June 30, 2015

Funding Source	Service	Unit Rate
Drug MediCal	Outpatient Drug Free Treatment	
	Day Care Rehabilitative Treatment	
Short Doyle MediCal	Assessment	$2.61 per minute
	Plan Development	$2.61 per minute
	Individual Therapy	$2.61 per minute
	Group Therapy	$2.61 per minute
	Collateral Services	$2.61 per minute
	Family Therapy	$2.61 per minute
	Rehabilitation Services	$2.61 per minute
	Crisis Intervention	$3.88 per minute
	Targeted Case Management	$2.02 per minute

* The BASN Allocation reflects your annual allocation, and includes the maximum allocation that was included in the amendment extending the term of the agreement through December 31, 2013.

Attachment C
Election of Third Party Billing Process

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

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

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

We, StarVista, elect option one.

_____ _____
Signature of authorized agent Name of authorized agent

_____
Telephone number

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

We, StarVista, elect option two.

SS Mitchell Sara Larios Mitchell, CEO
Signature of authorized agent Name of authorized agent

(650) 591-9623
Telephone number

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

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

Attachment D - Payor Financial Form

AGENCY NAME:

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

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

Responsible Party's Information (Guarantor):

Name _____ Phone _____ Relationship to Client _____ □ Self

Address _____ City _____ State _____ Zip Code_____

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

FINANCIAL ASSESSMENT – Annual UMDAP (Uniform Method of Determining Ability to Pay)

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

Number of Persons Dependent on Income _____

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

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

F. Housing Cost (Mortgage/Rent) $_____

3rd Party HEALTH INSURANCE INFORMATION

Health Plan or Insurance Company (Not employer)

Name of Company _____

Street Address _____

City _____

State _____ Zip _____

Insurance Co. phone number_____

Policy Number _____

Group Number_____

Name of Insured Person_____

Relationship to Client_____

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

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

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

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

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

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

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

Name of Interviewer _____ Phone Number_____ Best Time to Contact_____

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

San Mateo County Mental Health Services Use Only

ENTERED BY	**CLIENT ACCOUNT #**	**DATA ENTRY DATE**

Rev 06/05

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

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

Instructions for Obtaining Medi-Cal Eligibility Using Internet

- Double click on Internet Explorer
- Type in the address box: **https://www.medi-cal.ca.gov/eligibility**
- From the Login Center Transaction Services screen, enter
  Userid: **usually 5 zeros followed by your provider number**
- Enter state assigned password – call Medi-Cal Provider Relations Phone Support @ 1-800-541-5555
- Click on Submit or press enter
- From the Transaction Services screen, double click on Determine Patient's Eligibility
- From Perform Eligibility screen fill in the following fields:
  - Recipient ID – enter the client's Social Security # (without dashes)
  - Date of Birth – enter the client's DOB (mm/dd/yyyy)
  - Date of Card Issue – if unknown, enter today's date (mm/dd/yyyy)
  - Date of Service – enter the date on which the service is to be performed (mm/dd/yyyy)
  - Click on Submit or press enter

Note:

Click on Back - to return to Transaction Services screen

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

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

Instructions for Clearing Medi-Cal Share of Cost Using Internet

- Double click on Internet Explorer
- Type in the address box: ***https://www.medi-cal.ca.gov/eligibility***
- From the Login Center Transaction Services screen, enter Userid: **your provider number preceded by 5 zeros**
- Enter state assigned password - call Medi-Cal Provider Relations Phone Support @ 1-800-541-5555
- Click on Submit or press enter
- From the Transaction Services screen, double click on Determine Share of Cost
- From Perform SOC screen fill in the following fields:
    - Recipient ID – enter the client's Social Security # (without dashes)
    - Date of Birth – enter the client's DOB (mm/dd/yyyy)
    - Date of Card Issue – if unknown, and clearing service for the current month, enter today's date. If you are clearing a retroactive service, you must have the BIC issue date. (mm/dd/yyyy)
    - Date of Service – enter service date for the "SOC Clearance." (mm/dd/yyyy)
    - Procedure Code – enter the procedure code for which the SOC is being cleared. The procedure code is required. (90862, 90841, 90882, etc.)
    - Billed Amount – enter the amount in dollars and cents of the total bill for the procedure code. (ex. 100 dollars would be entered as 100.00). If you do not specify a decimal point, a decimal followed by two zeros will be added to the end of the amount entered.
    - Share of Cost Case Number – optional unless applying towards family member's SOC case
    - Amount of Share of Cost – optional unless a SOC case number was entered
    - Click on Submit or press enter

Note:

Click on Back - to return to Transaction Services screen

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

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

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

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

ATTACHMENT I

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

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

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

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

☐ a. Employs fewer than 15 persons. (or no employees)

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

Lillian Doherty
Name of 504 Person - Type or Print

StarVista
Name of Contractor(s) - Type or Print

610 Elm Street, Suite 212
Street Address or P.O. Box

San Carlos, CA 94070
City, State, Zip Code

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

SP Mitchell
Signature

Chief Executive Officer
Title of Authorized Official

10/28/13
Date

*Exception: DHHS regulations state that:

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