SECOND AMENDMENT TO AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND PYRAMID ALTERNATIVES, INC.

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

W I T N E S S E T H:

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

WHEREAS, the parties entered into an Agreement ("Original Agreement") for professional services on December 10, 2013 for a maximum obligation of $1,974,141, for the term January 1, 2014 through June 30, 2015; and

WHEREAS, on May 30, 2014 the Chief of the Health System authorized a first amendment to the agreement to provide a cost of living adjustment, increasing the maximum obligation by $26,271 to a new maximum of $2,000,412, with no change to the term of the Agreement; and

WHEREAS, it is now necessary and the mutual desire and intent of the parties hereto to amend the agreement a second time to provide substance use disorder treatment services, increasing the maximum obligation by $779,235 to a new maximum of $2,779,647 with no change to the term of the Agreement; and

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 "A2," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B2." The County reserves the right to withhold payment if the County determines that the quantity or quality of the work

performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed TWO MILLION SEVEN HUNDRED SEVENTY-NINE THOUSAND SIX HUNDRED FOURTY-SEVEN DOLLARS ($2,779,647).

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

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

4. All other terms and conditions of the 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

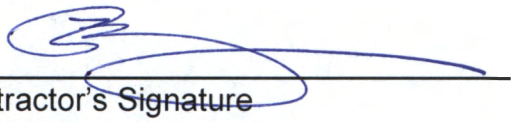
By:_____
President, Board of Supervisors
San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

PYRAMID ALTERNATIVES, INC.



Contractor's ~~Signature~~

Date: 09/29/14

EXHIBIT A2 – SERVICES
PYRAMID ALTERNATIVES, INC.
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 B2, 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 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://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 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 Treatment
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 as referenced in the AOD Provider Handbook. Adolescent Providers shall also adhere to the Youth Treatment Guidelines as referenced in the AOD Provider Handbook.

b. Intensive Outpatient Treatment
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. Perinatal Intensive Outpatient services must be in compliance with the DHCS PSN guidelines located at:http://www.dhcs.ca.gov/individuals/Documents/PSNG2014Final21214.pdf. Adolescent Providers shall also adhere to the Youth Treatment Guidelines set forth by the DHCS located at: http://www.dhcs.ca.gov/individuals/Documents/Youth Treatment Guidelines.pdf.

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 Professional of the Healing Arts (LPHA). 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 LPHA will provide frequent, regular updates regarding the participants' participation.
iv. Contractor will provide monthly updates regarding the participants' participation to the Case Manager and/ or CalWORKs, Realignment, Unified Reentry or Drug Court Team.

d. Drug Medi-Cal

Drug Medi-Cal (DMC) rates are contingent upon legislative action and approval of the annual State Budget. All claims must documented in accordance with DMC rules, guidelines, timelines, and provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure.

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 Perinatal regulations.

i. Outpatient Drug Free Treatment- outpatient service directed at stabilizing and rehabilitating persons with Substance Use Disorder diagnoses. Services include Individual Counseling and group Counseling. Each beneficiary shall receive at a minimum of two (2) group counseling sessions per month unless medically indicated otherwise.
   a) Individual Counseling is limited to intake, crisis intervention, collateral services and discharge planning. Sessions shall be at a minimum of fifty (50) minutes in duration.
   b) Group counseling shall be conducted with no less than four (4) and no more than ten (10) clients at the same time, only one of whom needs to be a Medi-Cal beneficiary. Sessions shall be at a minimum of ninety (90) minutes in duration.

ii. Intensive Outpatient Treatment(IOP) 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. For IOP group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

iii. Criminal Justice Programs
   a) Realignment (AB109)

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.

b) 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.

c) Unified Reentry
Contractor will provide authorized services to individuals meeting the Unified Reentry eligibility criteria as determined by the Service Connect Team.
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 clients based on assessed treatment need.

d) Drug Court
Contractor will provide authorized services to individuals meeting the Unified Reentry eligibility criteria as determined by the Drug Court Team.
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 clients based on assessed treatment need.

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. Contractor will provide monthly updates regarding the participants' participation to the Case Manager and/ or Realignment, Unified Reentry or Drug Court Team.

2. Treatment Planning and Documentation

Documentation of client services and progress in treatment shall be maintained in the client record. Providers shall adhere to documentation requirements for the service provided as described in the AOD Provider Handbook.

B. Description of Unique Program Services

Contractor shall provide a minimum of one (1) to two (2) days a week of Outpatient treatment. Services will include a minimum of two (2) individual counseling sessions per month and a minimum of three (3) hours of recovery-oriented group counseling per week. Program topics will include addiction and recovery, parenting skills, health issues, and ongoing educational workshops.

Contractor shall provide a minimum of three (3) to four (4) days a week of Intensive Outpatient/Day Treatment. Program shall consist of weekly group sessions, face-to-face individual sessions, process groups and education.

Contractor's basic alcohol and drug treatment program shall include:

1. Intake, assessment (using the Addiction Severity Index [ASI],) recovery planning, and relapse prevention, case management services, and follow-up at six (6) and twelve (12) months after intake for each program participant.

2. Ancillary services will include access to vocational and job training, medical services, ESL/GED, advanced education, mental health services, detoxification services and other drug treatment, HIV/AIDS, HEP A/B/C, and STD testing and education, and other appropriate services provided by the County of San Mateo. Education will be offered by Contractor.

3. Access will be provided to community involvement to encourage participants to be active in their community and in society. These activities may include community service, school or training programs, volunteer work or employment.

4. Collateral services will be provided to family members including education on substance abuse behavior and lifestyle, along with educational meetings on how to give support to the family member in treatment.

5. Program topics will include addiction and recovery, the 12-Step model of recovery, family dynamics, self-esteem, communication and conflict resolution, disease model of substance abuse, health issues, housing options, financial management, interviewing and job application skills, educational issues, and relapse prevention.

6. Cases coordination and referrals with other San Mateo County providers as necessary.

7. Aftercare services will be provided to program participants upon completion of Contractor's treatment program. Aftercare services will include:

   a. An aftercare plan developed with each program participant prior to the final phase of the treatment program; and
   b. Two (2) hours of relapse prevention each month for each program participant including ongoing program activities, group and individual support, education and ongoing links to community services.

8. Evaluation and referral for medical and co-occurring issues.

II. MENTAL HEALTH SERVICES

In full consideration of the payments herein provided for, Contractor shall provide Mental Health Services authorized by the San Mateo County Division of Behavioral Health and Recovery Services (BHRS), and as meet medical necessity. These services shall be provided in manner prescribed by the laws of California and in accord with the applicable laws, titles, rules, and regulations, including quality improvement requirements of the Short-Doyle/Medi-Cal Program. All payments under this Agreement must directly support services specified in this Agreement. The San Mateo County BHRS Documentation Manual ("County Documentation Manual") is included herein by reference. To the extent that there is inconsistency between a provision in the County Documentation Manual and this Agreement, the provisions in the County Documentation Manual shall prevail.

A. Mental Health Plan (Authorized by the Mental Health Plan)

1. General Description of Services

   Contractor shall provide services for clients under the MHP. These services shall be provided to Medi-Cal eligible beneficiaries, clients who are covered by Medi-Cal and Healthy Kids Programs, client caregivers who are covered by HealthWork, clients who are covered by the Health Plan of San Mateo CareAdvantage program for Medicare, and clients known to be indigent, for whom the MHP has assumed responsibility.

   a. All clients shall be authorized for service by the Mental Health Services Division's ACCESS Team. Separate authorizations shall be required for assessment and ongoing treatment services.

b. These services shall be provided in a manner prescribed by the laws of California and in accord with all other applicable laws, titles, rules, and regulations, including quality improvement requirements of the Short-Doyle/Medi-Cal Program. All payments under this agreement must directly support services specified in this Contract.

c. Services must be pre-authorized by the MHP.

d. After a clinical assessment is completed, Contractor shall notify the ACCESS Team within five (5) working days of completion of assessment with result of the assessment. If the results include a recommendation that Contractor provide further treatment, additional authorization must be obtained.

e. All services shall be provided by licensed, waivered or registered mental health staff.

f. Services shall include the following:

i. Initial Assessment Services
This includes clinical analysis of the history and current status of the client/enrollee's mental, emotional or behavioral condition.

ii. Treatment Services:

1) Individual Therapy
Individual Therapy are those therapeutic interventions consistent with the client's goals that focus primarily on symptom reduction as a means to improve functional impairments. Individual Therapy is usually delivered to an individual but may include family or significant support persons when the individual is present, but the focus of work is on the client and not on the family system.

2) Family Therapy
Family Therapy consists of contact with the client and one or more family members and/or significant support persons. Services shall focus on the care and management of the client's mental health conditions within the family system.

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

4) Collateral services, including contact with family and other service providers.
Collateral Services consists of contact with one or more family members and/or significant support persons (when the client is not present) which may include consultation and training to assist in better utilization of services and understanding mental illness. Collateral services include, but are not limited to, helping significant support persons to understand and accept the client's condition and involving them in service planning and implementation of service plan(s).

5) Clinical Consultation (via phone)
Clinical Consultations consists of contact with one or more mental health professionals for the purpose of obtaining advice for the evaluation or management of a specific problem and for care coordination.

2. Staffing

Contractor shall ensure that all services are provided by:

a. Licensed, waivered or registered mental health professionals;

b. Staff experienced in the provision of therapy services for co-occurring illnesses;

c. Staff experienced in the provision of therapy services to parents/caregivers who may have mental health issues which require intervention;

d. Staff capable of working with a culturally diverse population; and

e. Services may be provided by graduate school trainees as co-therapists of group or family therapy, provided that such trainees are supervised by licensed professionals.

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 make every effort reasonable effort including the establishment of systems for eligibility determination, billing and collection, to secure payment in accordance with BHRSAOD Policy 14-04. This includes:

    a. Screen all potential clients for health coverage;

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

    c. Collect reimbursement for the costs of providing services to persons who are entitled to insurance benefits, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program; and secure from patients or clients payments for services in accordance with their ability to pay.

    d. Advance authorization must be requested and granted from the BHRS Call Center prior to billing any client with health coverage to this county contract.

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 DMC for client services provided to Medi-Cal beneficiaries or transition client to DMC certified provider within thirty (30) days coverage; or
        ii. OHC Beneficiaries: provide and bill OHC provider for service, or transition client to OHC provider within thirty (30) days of coverage.

3. Medi-Cal Beneficiaries Seeking SUD Services

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

   b. If client has OHS in addition to Medi-Cal, Contractor must follow process established under ADP Bulletin 11-01 including future DHCS updates regarding the processes DMC 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:
      i. Contractor has submitted DMC Application for this service and facility and certification is pending DHCS approval; and the client cannot be referred to a DMC certified program and facility that is conveniently located for the client.
      ii. Contractor provides a medically necessary service to a beneficiary which is not covered under the CMS approved DMC benefit.

4. Drug Medi-Cal (DMC) Certification

   Contractor shall become a DMC certified provider with 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 CMS approved DMC benefit

e. Program and Client Requirements
   i. The beneficiary has an medically necessary need for service, and
      1) The medically necessary service is not covered by DMC.
      2) The Contractor provides 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 payers 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

a. BHRS has designed a service delivery system to improve quality and access of clients to services. BHRS services are divided in to six geographic community service areas.

b. Contractor will participate in activities to improve partnership and service delivery within the Community Service Area (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 Mental Health Services Act 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 SOC, 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. Contractors 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:

1. 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.

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

3. 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.

4. 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 DMC 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 Analyst/ 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 such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance;

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

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

   d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services 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 eight (8) hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

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

3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If contractor is unable to provide services in those languages, the contractor is expected to contact Access Call Center or their BHRS Analyst/Program Manager for consultation. If additional language resources are needed, please contact HEIM.

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

5. Technical Assistance

   Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the BHRS Analyst/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,

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 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, once there, type in "medi-cal suspended and ineligible provider list" in the search box.

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 DHCS 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; and

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. Surety Bond

Retain and show proof of a bond issued by a surety company in accordance with County policy for a licensee who may be entrusted with care and/or control of client's cash resources. Contractor shall submit proof of surety bond no later than July 1, 2015.

P. 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.

Q. 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). Special attention must be paid to documentation requirements for residential treatment facilities. Documentation shall be completed in compliance with the BHRS Policies & Documentation Manual (as defined in Paragraph II. of this Exhibit A2) 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).

R. 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.

S. 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.

T. 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.

U. 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.

V. 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 67% to 68%. Successful treatment discharge occurs when a program participant completes his/her treatment/recovery plan or is transferred for continued treatment.

END OF EXHIBIT A2

EXHIBIT B2 – PAYMENTS AND RATES
PYRAMID ALTERNATIVES, INC.
JANUARY 1, 2014 – JUNE 30, 2015

In full consideration of the services provided by Contractor in Exhibit "A2", 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

In any event, the maximum amount County shall be obligated to pay for all services rendered under this contract shall not exceed TWO MILLION SEVEN HUNDRED SEVENTY-NINE THOUSAND SIX HUNDRED FOURTY-SEVEN DOLLARS ($2,779,647).

1. 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 SIX HUNDRED TWENTY-SIX THOUSAND TWO HUNDRED THIRTY-NINE DOLLARS ($626,239). Rates are referenced in Schedule A2 – Fixed Rate Table.

a. Contractor shall be paid a total of TWO HUNDRED EIGHT THOUSAND SIX HUNDRED THREE DOLLARS ($208,603) for the term January 1, 2014 through June 30, 2014. Contractor shall be paid in six (6) monthly payments of THIRTY-FOUR THOUSAND SEVEN HUNDRED SIXTY-SEVEN DOLLARS ($34,767).

b. Contractor shall be paid a total of FOUR HUNDRED SEVENTEEN THOUSAND SIX HUNDRED THIRTY-SIX DOLLARS ($417,636) for the term July 1, 2014 through

June 30, 2015. Contractor shall be paid in twelve (12) monthly payments of THIRTY-FOUR THOUSAND EIGHT HUNDRED THREE DOLLARS ($34,803).

2. Fee for Service Aggregate

The maximum payment for alcohol and drug treatment services shall not exceed an aggregate amount of ONE MILLION NINE HUNDRED SEVENTEEN THOUSAND ONE HUNDRED FOURTEEN DOLLARS ($1,917,114). Rates are referenced in Schedule A2 – Fee for Service Aggregate Rate Table.

3. Fee for Service with Allocation

Service specific reimbursement rates for DMC FY 2014-15 are pending approval; and upon approval, shall be communicated to Contractor through an administrative memorandum that will serve as an amendment to the agreement.

The maximum payment for fee for service with allocation services shall not exceed an amount of ELEVEN THOUSAND TWO HUNDRED NINETY-FOUR DOLLARS ($11,294). Rates are referenced Schedule A2 – Fee for Service with Allocation Rate Table.

B. 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. Multiple Offender Programs
Contractor shall remit monthly to the BHRS AOD Administrator a seven percent (7%) administrative fee for MOP 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 DUI MOP.

3. 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.

C. Mental Health Plan

The maximum amount that County shall be obligated to pay for Mental Health Plan Services shall not exceed TWO HUNDRED TWENTY-FIVE THOUSAND DOLLARS ($225,000) for the term of the Agreement.

1. Contractor shall be paid a maximum of SEVENTY-FIVE THOUSAND DOLLARS ($75,000) for the term January 1, 2014 through June 30, 2014, for services described in Exhibit A2 Section II. A. of this Agreement.

2. Contractor shall be paid a maximum of ONE HUNDRED FIFTY THOUSAND DOLLARS ($150,000) for the term July 1, 2014 through June 30, 2015, for services described in Exhibit A2 Section II. A. 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.

Service Type	2013-15
90791 Assessment (per case)	$124.00

b. Treatment Services (non-MD)

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

Service Type	2013-15
90834 Individual Therapy (per session	$88.00
90853 Group Therapy, 60 minutes	$29.00
G9090 Group Therapy, 90 minutes	$48.00
G0120 Group Therapy, 120 minutes	$65.00
90847 Family Therapy (per hour; includes all	$90.00

members)	
90887 Collateral (per session)	$59.00
X8255 Clinical Consultation (telephone, 15 minutes)	$12.00
N0000 No Show (two per client)	$20.00

3. Medi-Cal cases seen under this contract are to be reimbursed by the Mental Health Division. No other revenue sources may be collected for Medi-Cal clients. Under no circumstances may Medi-Cal eligible clients be charged for services provided. Under no circumstances may Medi-Cal clients be charged for missed appointments.

D. 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.

E. Modifications

Modifications to the allocations in Paragraph A of this Exhibit B2 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.

F. 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.

G. 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.

H. 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

I. 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 A2). 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.

J. 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.

K. 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.

L. 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.

M. 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 State Department of Health Care Services.

N. Cost Report/Unspent Funds

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

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

the following year, provided that these funds are expended for SUD services approved by County and are retained in accordance with Paragraph N of this Exhibit B2.

O. Election of Third Party Billing Process – Medi-Cal 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 N of this Exhibit B2. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.

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

2. Option Two

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

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

P. 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.

Q. 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 B2

SCHEDULE A2
PYRAMID ALTERNATIVES, INC.
FIXED RATE TABLE

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 Outpatient	$100,008	$16,668	$50	2,000	33	9
County Funded Outpatient-Adult	$28,995	$4,833	$50	580	10	3
County Funded Outpatient-Adolescent	$5,000	$833	$50	100	2	0.4
County Funded Day Treatment	$49,429	$8,238	$151	327	10	2
CalWORKS Day Treatment	$2500	$416	$151	17	0.5	0.1
CalWORKS Outpatient	$2785	$464	$50	56	1	0.2
MHSA-Co-occuring	$18,592	$3,099	$50	372	6	1.7
County Bridge Match Funding*	$1,294	$215				
Outpatient			$50			
Intensive Day Tx			$151			
TOTAL	$208,603	$34,767				

July 1, 2014 – June 30, 2015

Services	Funding Amount	Monthly Funding Amount	Rate	Units of Service per FY	Clients to be Served	Slots
NRC Outpatient	$200,016	$16,668	$50	4,000	66	18
County Funded Outpatient-Adult	$50,565	$4,214	$50	1,011	17	5
County Funded Outpatient-Adolescent	$12,514	$1,042	$50	250	4	1
County Funded Day Treatment	$106,357	$8,863	$151	704	21	5
CalWORKS Day Treatment	$5,000	$417	$151	33	1	0.2
CalWORKS Outpatient	$6,000	$500	$50	120	2	1
MHSA Co-occuring	$37,184	$3,099	$50	744	12	3
TOTAL	$417,636	$34,803				

*Bridge Funding for Outpatient and Intensive Day Treatment is for the period of 1/1/14-3/31/14 & the flat rate is to be utilized at 100%

CalWORKs Outpatient Services - 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.

SCHEDULE A2
PYRAMID ALTERNATIVES, INC.
FEE FOR SERVICE AGGREGATE RATE TABLE

I. FEE FOR SERVICE AGGREGATE

January 1, 2014 – June 30, 2014

Funding Source & Services	Aggregate Maximum for all Providers	Unit Rate
Realignment Drug Court	$152,334	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Aftercare Treatment		$40.00 Per Staff Hour
Drug Testing		$30.00 Per Screening
Adult Drug Court 11550 Expansion	$76,978	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Aftercare Treatment		$40.00 Per Staff Hour
Drug Testing		$30.00 Per Screening
Individual and Family Therapy		$2.61 Per Minute
Reentry Achieve 180*	$2,500	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Reentry Achieve 180**	$183,000	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
AB 109 Criminal Justice Realignment	$139,439	
Outpatient Individual		$0.50 Per Minute
Outpatient Group		$1.33 Per Minute
Intensive Outpatient		$151 Per Visit Day
Individual and Family Therapy		$2.61 Per Minute
Drug Testing/Urine Analysis		$30.00 Per Screening
TOTAL	$554,251	

* Federally funded Achieve 180 services January 1, 2014 – March 31, 2014
** County funded Achieve 180 services April 1, 2014 – June 30, 2014

July 1, 2014 – June 30, 2015

Funding Source & Services	Aggregate Maximum for all Providers	Unit Rate
Realignment Drug Court	$304,668	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Aftercare Treatment		$40.00 Per Staff Hour
Drug Testing/Urine Analysis		$30.00 Per Screening
Individual and Family Therapy		$2.61 Per minute
Adult Drug Court 11550 Expansion	$153,956	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Aftercare Treatment		$40.00 Per Staff Hour
Drug Testing/Urine Analysis		$30.00 Per Screening
Individual and Family Therapy		$2.61 Per minute
Unified Reentry	$625,361	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Aftercare Treatment		$40.00 Per Staff Hour
Drug Testing/Urine Analysis		$30.00 Per Screening
Individual and Family Therapy		$2.61 Per minute
Criminal Justice Realignment	$278,878	
Outpatient Individual/Group		$50.00 Per Staff Hour
Intensive Outpatient		$120.00 Per Visit Day
Aftercare Treatment		$40.00 Per Staff Hour
Drug Testing/Urine Analysis		$30.00 Per Screen
Individual and Family Therapy		$2.61 Per minute
TOTAL	$1,362,863	

SCHEDULE A2
PYRAMID ALTERNATIVES, INC.
FEE FOR SERVICE WITH ALLOCATION RATE TABLE

I. FEE FOR SERVICE WITH ALLOCATION

January 1, 2014 – June 30, 2014

Funding Source & Service	Allocated to Provider	Unit Rate
County Bridge Funding- Adult	$1,294	
Outpatient Individual		$1.33 Per Minute
Outpatient Group		$0.50 Per Minute
Intensive Outpatient		$151.00 Per Day
TOTAL	$1,294	

July 1, 2014 – June 30, 2015

Funding Source & Service	Allocated to Provider	Unit Rate
DMC Allocation	$10,000	
Outpatient Individual		$67.38 Face to face visit (per person)
Outpatient Group		$26.23 Face to face visit (per person)
Intensive Outpatient		$56.44 Face to face visit (per day)
TOTAL	$10,000	

** The proposed rates and subsequent claim payments are contingent upon legislative action and approval of the FY 2014-2015 Budget Act.*

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.

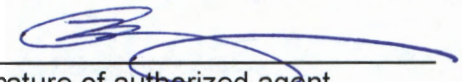
We, Pyramid Alternatives, Inc., elect option one.

_____ _____
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, Pyramid Alternatives, Inc., elect option two.


PAUL CHANG
Signature of authorized agent Name of authorized agent

(650) 516-0322
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 Behavioral Health and Recovery Services.

_____ _____ _____
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_____

San Mateo County Behavioral Health and Recovery 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.

☒ 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.

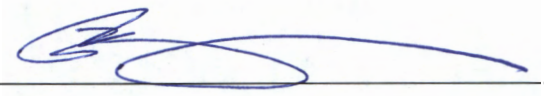
MARK PELHAM
Name of 504 Person - Type or Print

Pyramid Alternatives, Inc
Name of Contractor(s) - Type or Print

480 Manor Plaza
Street Address or P.O. Box

Pacifica, CA 94044
City, State, Zip Code

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


Signature

EXECUTIVE DIRECTOR
Title of Authorized Official

09/29/14
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."