STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213_DHCS (Rev. 01/13)

ORIGINAL

REGISTRATION NUMBER	AGREEMENT NUMBER
ef 13089989	12-89361

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

CONTRACTOR'S NAME (Also referred to as Contractor)
El Dorado County Health and Human Services Agency

2. The term of this Agreement is: May 1, 2013 through June 30, 2018

3. The maximum amount of this Agreement is: $ 8,113,337,000
Eight billion, one hundred thirteen million, three hundred thirty-seven thousand dollars.

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	2 pages
Exhibit A Attachment I – Service, Administrative and Operational Requirements	56 pages
Exhibit A Attachment II – Definitions	2 pages
Exhibit B – Budget Detail and Payment Provisions	6 pages
Exhibit C * – General Terms and Conditions	GTC 610
Exhibit D (F) – Special Terms and Conditions (Attached hereto as part of this agreement) Notwithstanding Provisions 2, 3, 4, 6 ,8, 12, 14, 22, 25, 29, and 30 which do not apply to this agreement.	26 pages
Exhibit E – Additional Provisions	11 pages
Exhibit F – Privacy and Information Security Provisions	28 pages

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at http://www.ols.dgs.ca.gov/Standard Language/default.htm.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
El Dorado County Health and Human Services Agency

BY *(Authorized Signature)* ✍ [signature]
DATE SIGNED *(Do not type)* 4/23/13

PRINTED NAME AND TITLE OF PERSON SIGNING
Ron Briggs, Chair, Board of Supervisors

ATTEST: James S. Mitrisin
Clerk of the Board of Supervisors
By [signature]
Marcie MacFarland, Deputy Clerk

ADDRESS
3057 Briw Road, Suite A
Placerville, CA 95667

STATE OF CALIFORNIA

AGENCY NAME
Department of Health Care Services

BY *(Authorized Signature)* ✍ Cindy Walton, Chief
DATE SIGNED *(Do not type)* 9-16-13

PRINTED NAME AND TITLE OF PERSON SIGNING
Andrew Young, Chief, Contract Management Unit Program Support Branch

ADDRESS
1501 Capitol Avenue, Suite 71.5195, MS 1403, P.O. Box 997413,
Sacramento, CA 95899-7413

California Department of General Services Use Only

[X] Exempt per: W&I Code § 14703

ORIGINAL

Exhibit A Attachment I
Service, Administrative and Operational Requirements

1. Provision of Services

A. The Contractor shall provide, or arrange and pay for, all medically necessary covered Specialty Mental Health Services to beneficiaries, as defined for the purposes of this contract, of El Dorado County.

B. The Contractor shall ensure that all medically necessary covered Specialty Mental Health Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered Specialty Mental Health Service solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in the California Code of Regulations (Cal. Code Regs.), title (tit.) 9, §§1820.205, 1830.205, and 1830.210.

C. The Contractor shall make all medically necessary covered Specialty Mental Health Services available in accordance with Cal. Code Regs., tit. 9, §§ 1810.345 and 1810.405, and 42 Code of Federal Regulations (C.F.R.) § 438.210 and shall ensure:

1) The availability of services to address beneficiaries' emergency psychiatric conditions 24 hours a day, 7 days a week.

2) The availability of services to address beneficiaries' urgent conditions as defined in Cal. Code Regs., tit. 9, §1810.253, 24 hours a day, and 7 days a week.

3) Timely access to routine services determined by the Contractor to be required to meet beneficiaries' needs.

D. The Contractor shall provide second opinions in accordance with Cal. Code Regs., tit. 9, § 1810. 405(e).

E. The Contractor shall provide out-of-plan services in accordance with Cal. Code Regs., tit. 9, §§1830.220 and 1810.365. The timeliness standards specified in Cal. Code Regs., tit. 9, 1810.405 apply to out-of-plan services, as well as in-plan services.

F. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with Cal. Code Regs., tit. 9, §1830.225 and 42 C.F.R. § 438.6(m).

G. In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor shall not exclude a beneficiary solely on the ground that the provider making the diagnosis has used the International

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Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

H. For services provided pursuant to Section 3 of this Attachment, entitled "Emergency Psychiatric Condition Reimbursement", the Contractor shall consider the following ICD-9 diagnosis codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use DSM IV coding.

Table 1 - Included ICD-9 Diagnoses - All Places of Services except Hospital Inpatient

295.00 – 298.9	302.8 - 302.9	311 - 313.82
299.1 – 300.89	307.1	313.89 – 314.9
301.0 – 301.6	307.3	332.1 – 333.99*
301.8 – 301.9	307.5 - 307.89	787.6
302.1 – 302.6	308.0 - 309.9	

*Note: Treatment of diagnoses 332.1 - 333.99, Medication Induced Movement Disorders, is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.

Table 2 - Included ICD-9 Diagnoses - Hospital Inpatient Place of Service

290.12 – 290.21	299.10 - 300.15	308.0 – 309.9
290.42 – 290.43	300.2 - 300.89	311 – 312.23
291.3	301.0 - 301.5	312.33 - 312.35
291.5 - 291.89	301.59 - 301.9	312.4 – 313.23
292.1 - 292.12	307.1	313.8 – 313.82
292.84 – 292.89	307.20 - 307.3	313.89 - 314.9
295.00 – 299.00	307.5 - 307.89	787.6

2. Availability and Accessibility of Service

Availability of Services

A. Pursuant to 42 C.F.R. § 438.206(a) and (b), the Contractor shall ensure the availability and accessibility of adequate numbers and types of providers of medically necessary services. At a minimum, the Contractor shall meet the following requirements:

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1) Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, the Contractor must consider the following:

   a) The anticipated number of Medi-Cal eligible clients.

   b) The expected utilization of services, taking into account the characteristics and mental health needs of beneficiaries.

   c) The expected number and types of providers in terms of training and experience needed to meet expected utilization.

   d) The numbers of network providers who are not accepting new beneficiaries.

   e) The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

   f) To the extent required by Cal. Code Regs., tit. 9, §1830.220, for inpatient services, if the Contractor is unable to provide necessary medical services covered under the contract to a particular beneficiary, the Contractor must adequately and timely cover these services out of network for the beneficiary, for as long as the Contractor is unable to provide them.

   g) Pursuant to 42 C.F.R. § 438.206(b)(5) and consistent with Cal. Code Regs., tit. 9, §1830.220, the Contractor shall require that out-of-network providers coordinate authorization and payment with the Contractor. As is consistent with Cal. Code Regs., tit. 9, §1810.365, the Contractor must ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network.

   h) The Contractor shall demonstrate that its providers are credentialed as required by 42 C.F.R. § 438.214.

Access to Services

B. Timely Access. In accordance with 42 C.F.R. § 438.206(c)(1), the Contractor shall comply with the requirements set forth in Cal. Code Cal. Code Regs., tit. 9, §1810.405, including the following:

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1) Meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services.

2) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor, or another Mental Health Plan.

3) Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.

4) Establish mechanisms to ensure that network providers comply with the timely access requirements;

5) Monitor network providers regularly to determine compliance with timely access requirements;

6) Take corrective action if there is a failure to comply with timely access requirements.

Adequate Capacity and Standards

C. Documentation of adequate capacity and services. Pursuant to 42 C.F.R. § 438.207(b), the Contractor must, when requested by the Department, submit documentation to the Department, in a format specified by the Department, and after receiving reasonable advance notice of its obligation, to demonstrate that the Contractor:

1) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries for the service area.

2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

D. Consistent with 42 C.F.R. § 438.207(c)(2), whenever there is a change in the Contractor's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries, the Contractor shall report this to the Department, including details regarding the change and plans to maintain adequate services and providers available to beneficiaries.

Coordination and Continuity of Care

Exhibit A Attachment I
Service, Administrative and Operational Requirements

E. Coordination of health care services. The Contractor must implement procedures to:

1) Coordinate the services that the Contractor either furnishes or arranges to be furnished to the beneficiary with services that the beneficiary receives from any other Medi-Cal managed care plan or MHP in accordance with Cal. Code Regs., tit. 9 §1810.425.

2) Ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, to the extent that such provisions are applicable.

3) Enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with Cal. Code Regs., tit. 9, § 1810.370. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans.

Authorization of Services

F. Pursuant to 42 C.F.R. § 438.210(b), the Contractor shall implement mechanisms to assure authorization decision standards are met. The Contractor shall:

1) Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.

2) Have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.

3) Have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

4) Have decisions made within the timeframes outlined for service authorizations in 42 C.F.R. § 438.210(d), and notices of action related to such decisions provided within the timeframes set forth in 42 C.F.R. § 438.404(c).

5) Provide that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

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G. The Contractor shall act on an authorization request for treatment for urgent conditions within one hour of the request per Cal. Code Regs., tit. 9, § Cal. Code Regs., tit. 9, § 1810.405(c).

H. Pursuant to 42 C.F.R. § 431.201, the Contractor shall define service authorization request in a manner that at least includes a beneficiary's request for the provision of a service.

3. Emergency Psychiatric Condition Reimbursement

A. The Contractor shall pay for services for emergency psychiatric conditions received by a beneficiary from providers, whether or not the provider has a subcontract with the Contractor. Such services shall not be subject to prior authorization.

B. "Post-stabilization care services" means covered services related to an emergency medical condition that are provided after a beneficiary is stabilized in order to maintain the stabilized condition.

C. The Contractor shall comply with 42 C.F.R. § 438.114, regarding emergency, post stabilization services. For purposes of this section, emergency and post stabilization services includes acute psychiatric inpatient hospital professional services (as defined in Cal. Code Regs., tit. 9, § Section 1810.237.1) which are related to an emergency medical condition or post-stabilization care. The Contractor shall apply the definitions contained in 42 C.F.R. § 438.114. To the extent that there is a conflict between the definitions in 42 C.F.R. § 438.114, and the Contractor's obligations as described in this section, the federal regulation shall prevail.

1) If an emergency room provider, hospital or fiscal agent of a provider or hospital does not notify the Contractor of the beneficiary's screening and treatment, the Contractor must allow a minimum of ten calendar days after the beneficiary presents for emergency services or acute psychiatric inpatient hospital professional services before refusing to cover emergency services or acute psychiatric inpatient hospital professional services for this reason.

2) A beneficiary who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

3) The Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

4) The attending emergency physician, or the provider actually treating the beneficiary, is responsible for determining when the beneficiary is

sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor.

D. The Contractor shall comply with 42 C.F.R. § 438.114(d)(ii,) and Cal. Code Regs., tit. 9, § Cal. Code Regs., tit. 9, §1820.225, regarding prior payment authorization for an emergency admission, whether voluntary or involuntary.

E. The Contractor shall comply with Cal. Code Regs., tit. 9, § 1830.215, regarding payment authorizations.

4. Provider Selection and Certification

A. The Contractor shall comply with Cal. Code Regs., tit. 9, § 1810.435, in the selection of providers and shall review its providers for continued compliance with standards at least once every three years.

B. The Contractor shall comply with the provisions of 42 C.F.R. §§ 455.104, 455.105, 1002.203, 1002.3, which relate to the provision of information about provider business transactions and provider ownership and control, prior to entering into a contract and during certification or re-certification of the provider.

C. "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which specialty mental health services are delivered by no more than two employees or contractors of the provider.

D. Pursuant to 42 C.F.R. § 438.12(a)(1), the Contractor may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

E. Pursuant to 42 C.F.R. § 438.12(a)(2), in all contracts with providers the Contractor must comply with the requirements in 42 C.F.R. § 438.214.

F. The Contractor shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract;

G. Contractor shall only use licensed, registered, or waivered providers acting within their scope of practice for services which require a license, waiver, or registration, consistent with Welfare and Institutions Code Section 5751.2 and Cal. Code Regs., tit. 9, § 1840.314(d).

H. Consistent with 42 C.F.R. § 438.214, the contractor shall have written policies and procedures for selection, retention, credentialing and recredentialing of providers; the provider selection policies and procedures must not discriminate against

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particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

I. The Contractor shall certify, or use another mental health plan's certification documents to certify, the organizational providers that subcontract with the Contractor to provide covered services in accordance with Cal. Code Regs., tit. 9, §1810.435, and the requirements specified prior to the date on which the provider begins to deliver services under the contract, and once every three years after that date. The on-site review required by Cal. Code Regs., tit. 9, § 1810.435(d), as a part of the certification process, shall be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

J. The Contractor may allow an organizational provider to begin delivering covered services to beneficiaries at a site subject to on-site review prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on-site review is the latest of these three (3) dates: 1) the date the provider's request for certification is received by the Department in accordance with the Contractor's certification procedures; 2) the date the site was operational; or 3) the date a required fire clearance was obtained. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the provider begins delivering covered services to beneficiaries at the site.

K. The Contractor may allow an organizational provider to continue delivering covered services to beneficiaries at a site subject to on-site review as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the recertification of the provider is due.

L. The Contractor and/or the Department shall each verify through an on-site review that:

1) The organizational provider possesses the necessary license to operate, if applicable, and any required certification.

2) The space owned, leased or operated by the provider and used for services or staff meets local fire codes.

3) The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary, and in good repair.

4) The organizational provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of beneficiaries and

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staff.

5) The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required state or federal notices (DRA), and procedures for reporting unusual occurrences relating to health and safety issues.

6) The organizational provider maintains client records in a manner that meets the requirements of the Contractor, the requirements of Section 14 of this Attachment, and applicable state and federal standards.

7) The organizational provider has sufficient staff to allow the Contractor to claim federal financial participation (FFP) for the services that the organizational provider delivers to beneficiaries, as described in Cal. Code Regs., tit. 9, § 1840.344 through § 1840.358, as appropriate and applicable.

8) The organizational provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

9) The organizational provider's head of service, as defined Cal. Code Regs., tit. 9, § 622 through § 630, is a licensed mental health professional or other appropriate individual as described in these sections.

10) For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:

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

    b) Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.

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

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

    e) Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened.

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f) A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.

g) Policies and procedures are in place for dispensing, administering and storing medications.

M. For organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with Section 8 of this exhibit.

N. When an on-site review of an organizational provider would not otherwise be required and the provider offers day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Section 8 of this exhibit.

O. On-site review is not required for hospital outpatient departments which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.

P. On-site review is not required for primary care and psychological clinics, as defined in the Health and Safety (Health & Saf.) Code section 1204.1 and licensed under the Health and Saf. Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license.

Q. When on-site review of an organizational provider is required, the Contractor or the Department, as applicable, shall conduct an on-site review at least once every three years. Additional certification reviews of organizational providers may be conducted by the Contractor or Department, as applicable, at its discretion, if:

1) The provider makes major staffing changes.

2) The provider makes organizational and/or corporate structure changes (example: conversion to non-profit status).

3) The provider adds day treatment or medication support services when medications are administered or dispensed from the provider site.

4) There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

5) There is a change of ownership or location.

6) There are complaints regarding the provider.

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7) There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community.

R. The Contractor shall monitor the performance of its subcontractors on an ongoing basis for compliance with the terms of this contract and shall subject the subcontractors' performance to periodic formal review, at a minimum in accordance with the recertification requirements. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor shall take corrective action.

5. Recovery from Other Sources or Providers

A. The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.

B. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this contract shall be reduced by the amount recovered.

C. The Contractor shall maintain accurate records of monies recovered from other sources.

D. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this contract.

6. Subrogation

In the event a beneficiary is injured by the act or omission of a third party, or has a potential or existing claim for a workers' compensation award, or a claim/recovery through uninsured motorist coverage, the right to pursue subrogation and the receipt of payments shall be as follows:

A. Contractor may submit to the Department claims for Medi-Cal covered services rendered, but Contractor shall not make claims to or attempt to recoup the value of these services from the above-referenced entities.

B. Contractor shall notify the Department within 10 days of discovery of all cases that could reasonably result in recovery by the beneficiary of funds from a third party, third party insurance carrier, workers' compensation award, and/or uninsured motorist coverage.

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C. If the Contractor receives any requests by subpoena from attorneys, insurers, or beneficiaries for copies of bills, the Contractor shall provide the Department with a copy of any document released as a result of such request. Additionally, the Contractor shall provide the name, address and telephone number of the requesting party.

D. The Contractor also agrees to assist the Department, upon request, to provide within thirty (30) days, payment information and copies of paid invoices/claims for covered services.

E. The value of the covered services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount to subcontracted providers or out-of-plan providers for similar services.

F. The information provided to the Department shall include the following data:

1) Beneficiary name;

2) 14-digit Medi-Cal number;

3) Social security number or Client Identification Number (CIN);

4) Date of birth;

5) Contractor name;

6) Provider name (if different from Contractor);

7) Dates of service;

8) Diagnosis code and/or description of illness;

9) Procedure code and/or description of services rendered;

10) Amount billed by a Subcontractor or out-of-plan provider to the Contractor (if applicable);

11) Amount paid by other health insurance to the Contractor or Subcontractor;

12) Amount and date paid by the Contractor to subcontractor or out-of-plan provider (if applicable); and

13) Date of denial and reasons (if applicable).

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G. The Contractor shall also provide the Department with the name, address, and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

H. Information sent to the Department, pursuant to this section, shall be sent to: State Department of Health Care Services, Third Party Liability Branch, 1500 Capitol Ave., Suite 320, Sacramento, CA 95814.

7. Beneficiary Brochure and Provider List

A. The Contractor shall be responsible for the production and update of its booklet section(s) and provider list in accordance with 42 C.F.R. § 438.10 and Cal. Code Regs., tit. 9, §1810.360. The Contractor shall establish criteria to update its booklet and provider list.

Pursuant to 42 C.F.R. § 438.10, the Contractor shall:

1) Notify all beneficiaries of their right to change providers;

2) Notify all beneficiaries of their right to request and obtain the following information:

a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the beneficiary's service area, including identification of providers that are not accepting new patients.

b) Any restrictions on the beneficiary's freedom of choice among network providers.

c) Beneficiary rights and protections, as specified in 42 CFR § 438.100.

d) The amount, duration, and scope of benefits available under this Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.

e) Procedures for obtaining benefits, including authorization requirements.

f) The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers.

g) The extent to which, and how, after-hours and emergency coverage are provided, including:

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i. What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in 42 C.F.R. § 438.114(a).

ii. The fact that prior authorization is not required for emergency services.

iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.

v. The fact that, subject to the provisions of 42 C.F.R. § 438.10(f)(6), the beneficiary has a right to use any hospital or other setting for emergency care.

vi. The post-stabilization care services rules set forth in 42 C.F.R. § 422.113(c).

h) Cost sharing, if any.

i) How and where to access any benefits that are available under the State Plan but are not covered under this Contract, including any cost sharing, and how any necessary transportation is provided. Pursuant to 42 C.F.R. § 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. Pursuant to 42 C.F.R. § 438.102(b)(1), the Contractor must provide information about the services it does not cover on moral or religious grounds.

B. The Contractor shall ensure that the general program literature it uses to assist beneficiaries in accessing services including, but not limited to, the booklet required by Cal. Code Regs., tit. 9, § 1810.360, materials explaining the beneficiary problem resolution and fair hearing processes required by Cal. Code Regs., tit. 9, § 1850.205(c)(1), and mental health education materials used by the Contractor, are available in the threshold languages of the County in compliance with 42 C.F.R. § 438.10(c)(3).

C. Pursuant to 42 C.F.R. § 438.10(c)(4) and (5) and Cal. Code Regs., tit. 9, § 1810.410, the Contractor must make oral interpretation and sign language services available free of charge to each beneficiary. This applies to all non-English languages and not just those identified as prevalent. The Contractor must notify

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beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

D. Pursuant to 42 C.F.R. § 438.10(g) and Cal. Code Regs., tit. 9, § 1850.205(c)(1), the booklet shall include grievance, appeal and fair hearing procedures and timeframes, as provided in 42 C.F.R. §§ 438.400 through 438.424, using a Department-developed or Department-approved description that must include the following:

1) For State Fair Hearing

   a) The right to hearing;

   b) The method for obtaining a hearing; and

   c) The rules that govern representation at the hearing.

2) The right to file grievances and appeals.

3) The requirements and timeframes for filing a grievance or appeal

4) The availability of assistance in the filing process.

5) The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone.

6) The fact that, when requested by the beneficiary:

   a) Benefits will continue if the beneficiary files an appeal or a request for State Fair Hearing within the timeframes specified for filing.

7) The appeal rights that the Department has chosen to make available to providers in Cal. Code Regs., tit. 9, § 1850.315, to challenge the Contractor's failure to cover a service.

8) Advance Directives, as set forth in 42 C.F.R. § 438.6(i)(22).

9) Additional information that is available upon request, includes the following:

   a) Information on the structure and operation of the Contractor.

   b) Physician incentive plans as set forth in 42 C.F.R. § 438.6(h).

E. The Contractor shall provide beneficiaries with a copy of the booklet and provider list when the beneficiary first accesses services and thereafter upon request in accordance with Cal. Code Regs., tit. 9, § 1810.360.

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F. The Contractor shall not make changes to any of the content in the statewide section of the booklet unless directed to do so, in writing, by the Department.

G. The Contractor shall ensure any changes to the English version of the booklet are also included in the county's threshold languages and made available in alternate formats appropriate to the beneficiary population.

H. The Contractor shall ensure written materials are produced in a format that is easily understood and available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency as required by 42 C.F.R. § 438.10(d)(1). Pursuant to 42 C.F.R. § 438.10(d)(2), the Contractor shall inform beneficiaries that information is available in alternate formats and how to access those formats.

I. The Contractor shall ensure that the booklet above includes the current toll-free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week.

J. The Contractor shall ensure that provider directories:

1) Include information on the category or categories of services available from each provider;

2) Contain the names, locations, and telephone numbers of current contracted providers by category;

3) Identify options for services in languages other than English and services that are designed to address cultural differences and;

4) Provide a means by which a beneficiary can identify which providers are not accepting new beneficiaries.

K. As required by 42 C.F.R. § 438.10(f)(4), when there is a change that the State defines as significant in the scope of specialty mental health services covered by the Contractor, the update, in the form of a booklet insert, shall be provided to beneficiaries at least 30 days prior to the change.

L. Consistent with 42 C.F.R. § 438.10(f)(5), the Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider.

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8. Requirements for Day Treatment Intensive and Day Rehabilitation

A. The Contractor shall require providers to request payment authorization for day treatment intensive and day rehabilitation services:

1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.

2) At least every three months for continuation of day treatment intensive.

3) At least every six months for continuation of day rehabilitation.

4) Contractor shall also require providers to request authorization for mental health services, as defined in Cal. Code Regs., tit. 9, § 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in Cal. Code Regs., tit. 9, §1810.216 and § 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.

B. The Contractor shall not delegate the payment authorization function to providers. When the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the payment authorization function does not include staff involved in the provision of day treatment intensive, day rehabilitation services, or mental health services provided concurrent to day treatment intensive or day rehabilitation services.

C. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of Cal. Code Regs., tit. 9, §§ 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352.

D. The Contractor shall require that providers include, at a minimum, the following day treatment intensive and day rehabilitation service components:

1) Community meetings. These meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and beneficiaries. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that beneficiaries or staff wish to discuss to elicit support of the group and conflict resolution. Community meetings shall:

a) For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.

b) For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, or

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marriage and family therapist; and a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.

2) Therapeutic milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

3) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.

4) Skill-building groups. In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.

5) Adjunctive therapies. These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs identified in the client plan.

E. Day treatment intensive shall additionally include:

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1) Psychotherapy. Psychotherapy means the use of psychological methods within a professional relationship to assist the beneficiary or beneficiaries to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

2) Mental Health Crisis Protocol. The Contractor shall ensure that there is an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.

3) Written Weekly Schedule. The Contractor shall ensure that a weekly detailed schedule is available to beneficiaries and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

F. Staffing Requirements. Staffing ratios shall be consistent with the requirements in Cal. Code Regs., tit. 9, § 1840.350, for day treatment intensive, and Cal. Code Regs., tit. 9, § 1840.352 for day rehabilitation. For day treatment intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.

1) Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, and caregiver contacts).

2) The Contractor shall require that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

3) The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables

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Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

G. If a beneficiary is unavoidably absent and does not attend all of the scheduled hours of the day rehabilitation or day treatment intensive program, the Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day. The Contractor shall require that a separate entry be entered in the beneficiary record documenting the reason for the unavoidable absence and the total time (number of hours and minutes) the beneficiary actually attended the program that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

H. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation standards described in Section 11 of this exhibit. The documentation shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the beneficiary actually attended the program. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist, or a registered nurse who is either staff to the day treatment intensive program or the person directing the services.

I. The Contractor shall ensure that day treatment intensive and day rehabilitation have at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult beneficiaries may decline this service component. The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

J. Written Program Description. The Contractor shall ensure there is a written program description for day treatment intensive and day rehabilitation. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this

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section. The Contractor shall review the written program description for compliance with this section with prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

K. Additional higher or more specific standards. The Contractor shall retain the authority to set additional higher or more specific standards than those set forth in this contract, provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.

L. Continuous Hours of Operation. The Contractor shall ensure that the provider applies the following when claiming for day treatment intensive and day rehabilitation services:

1) A half day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

2) A full-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

3) Although the beneficiary must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.

4) The requirement for continuous hours or operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

9. Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as defined in Cal. Code Regs., tit. 9, § 1810.215. TBS are intensive, one-to-one services designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. TBS are available to beneficiaries in accordance with the Department of Mental Health Information Notice 08-38, the TBS Coordination of Care Best Practices Manual, version 2 (October 2010), and the TBS Documentation Manual, version 2 (October 2009).

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10. Procedures for Serving Child Beneficiaries Placed Out-of-County

A. In accordance with Cal. Code Regs., tit. 9, § 1830.220, the Contractor in the child's county of origin shall provide or arrange for medically necessary specialty mental health services for children in a foster care aid code residing outside their counties of origin.

B. The Contractor shall use the standard forms issued by the Department, or the electronic equivalent of those forms generated from the Contractor's Electronic Health Record System, when a child in a foster care aid code is placed outside of his/her county of origin. The standard forms are:

1) Client Assessment,

2) Client Plan,

3) Service Authorization Request,

4) Client Assessment Update,

5) Progress Notes – Day Treatment Intensive Services,

6) Progress Notes – Day Rehabilitation Services,

7) Organizational Provider Agreement (Standard Contract).

C. The Contractor may request an exemption from using the standard documents if the Contractor is subject to an externally placed requirement, such as a federal integrity agreement, that prevents the use of the standardized forms. The Contractor shall request this exemption from the Department in writing.

D. The Contractor shall ensure that the MHP in the child's adoptive parents' county of residence provides medically necessary specialty mental health services to a child in an Adoption Assistance Program (AAP) aid code residing outside his or her county of origin in the same way as the MHP would provide services to an in-county child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS).

E. The MHP in the child's legal guardians' county of residence shall provide medically necessary specialty mental health services to a child in a Kin-GAP aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility in MEDS.

F. The Contractor shall comply with timelines specified in Cal. Code Regs., tit. 9, § 1830.220(b)(4)(A)(1-3), when processing or submitting authorization requests for

children in a foster care, AAP, or Kinship Guardian Assistance Payment (Kin-GAP) aid code living outside his or her county of origin.

G. The Contractor shall submit changes to its procedures for serving beneficiaries placed outside their counties of origin pursuant to Welf. & Inst. Code § 14716 when those changes affect 25 percent or more of the Contractor's beneficiaries placed out of county. The Contractor's submission shall also include significant changes in the description of the Contractor's procedures for providing out-of-plan services in accordance with Cal. Code Regs., tit. 9, § 1830.220, when a beneficiary requires services or is placed in a county not covered by the Contractor's normal procedures.

11. Documentation Standards

The Contractor shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in this section and any standards set by the Contractor. The Contractor may monitor performance so that the documentation of care provided will satisfy the requirements set forth below. The documentation standards for beneficiary care are minimum standards to support claims for the delivery of specialty mental health services. All standards shall be addressed in the beneficiary record; however, there is no requirement that the records have a specific document or section addressing these topics.

A. Assessment

1) The Contractor shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed. For children or certain other beneficiaries unable to provide a history, this information may be obtained from the parents/care-givers, etc.

a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;

b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;

c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

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d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;

e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;

f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;

i) A mental status examination;

j) A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,

k) Additional clarifying formulation information, as needed.

2) Timeliness/Frequency Standard for Assessment. The Contractor shall establish written standards for timeliness and frequency for the elements identified in item A of this section.

B. Client Plans

1) The Contractor shall ensure that Client Plans:

a) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

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b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;

c) Have a proposed frequency and duration of intervention(s);

d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b)); have interventions that are consistent with the client plan goal;

e) Be consistent with the qualifying diagnoses;

f) Be signed (or electronic equivalent) by:

i. The person providing the service(s), or,

ii. A person representing a team or program providing services, or

iii. A person representing the Contractor providing services; or

iv. By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved category:

a) A physician,

b) A licensed/waivered psychologist,

c) A licensed/registered/waivered social worker,

d) A licensed/registered/waivered marriage and family therapist, or

e) A registered nurse, including but not limited to nurse practitioners, and clinical nurse specialists.

g) Include documentation of the beneficiary's participation in and agreement with the client plan, as described in Cal. Code Regs., tit. 9, § 1810.440(c)(2)(A)(B).

i. Examples of acceptable documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary signature on the

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plan, or a description of the beneficiary's participation and agreement in the client record;

ii. The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:

a) The beneficiary is expected to be in long term treatment as determined by the MHP and,

b) The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service;

iii. When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.

2) There shall be documentation in the client plan that a copy of the client plan was offered to the beneficiary.

3) The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition.

A. Progress Notes

1) The Contractor shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:

a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;

b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

d) The date the services were provided;

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e) Documentation of referrals to community resources and other agencies, when appropriate;

f) Documentation of follow-up care, or as appropriate, a discharge summary; and

g) The amount of time taken to provide services; and

h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.

2) Timeliness/Frequency of Progress Notes. Progress notes shall be documented at the frequency by type of service indicated below:

a) Every Service Contact:

i. Mental Health Services;

ii. Medication Support Services;

iii. Crisis Intervention;

iv. Targeted Case Management;

b) Daily:

i. Crisis Residential;

ii. Crisis Stabilization (1x/23hr);

iii. Day Treatment Intensive; and

c) Weekly:

i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;

ii. Day Rehabilitation;

iii. Adult Residential.

B. Other

1) All entries to the beneficiary record shall be legible.

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2) All entries in the beneficiary record shall include:

   a) The date of service;

   b) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.

   c) The date the documentation was entered in the beneficiary record.

3) The Contractor shall have a written definition of what constitutes a long term care beneficiary.

4) Contractor shall require providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the beneficiary.

12. Cultural Competence Plan

The Contractor shall comply with the provisions of the Contractor's Cultural Competence Plan submitted in accordance with Cal. Code Regs., tit. 9, § 1810.410, and approved by the Department. The Contractor shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually.

13. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan pursuant to Cal. Code Regs., tit. 9, § 1810.310 as approved by the Department, including the administration of beneficiary problem resolution processes as required by Cal. Code Regs., tit. 9, § 1850.205 through § 1850.208. The Contractor shall obtain written approval by the Department prior to making any changes to the Implementation Plan as approved by the Department. The Contractor may implement the changes after thirty (30) calendar days if the Department does not respond in writing within thirty calendar (30) days as provided in Cal. Code Regs., tit. 9, § 1810.310.

14. Additional Provisions

A. Books and Records

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This provision is a supplement to provision number seven (Audit and Record Retention) in Exhibit D(F) which is attached hereto as part of this agreement.

The Contractor shall maintain such books and records as are necessary to disclose how the Contractor discharged its obligations under this contract. These books and records shall identify the quantity of covered services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the beneficiaries who received covered services, the manner in which the Contractor administered the provision of specialty mental health services and the cost thereof.

Such books and records shall include, but are not limited to, all physical records originated or prepared pursuant to performance under this contract including: working papers, reports submitted to the Department, financial records, all medical and treatment records, medical charts and prescription files, and other documentation pertaining to services rendered to beneficiaries. These books and records shall be maintained for a minimum of three years after the final payment is made and all pending matters closed, or, in the event the Contractor has been notified that the Department, HHS, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the contract, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later.

The Contractor agrees to include in any subcontract for a sum in excess of $10,000 which utilizes state funds, a provision that states: "The contracting parties shall be subject to the examination and audit of the Department or Auditor General for a period of three years after final payment under contract (Government Code § 8546.7)." The Contractor shall also be subject to the examination and audit of the Department and the State Auditor General for a period of three years after final payment under contract (Government Code § 8546.7).

B. Transfer of Care

Prior to the termination or expiration of this contract, and upon request by the Department, the Contractor shall assist the State in the orderly transfer of mental health care for beneficiaries in El Dorado County. In doing this, the Contractor shall make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor that is necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction shall be borne by the Department. In no circumstances shall a beneficiary be billed for this service.

C. Department Policy Letters

The Contractor shall comply with all policy letters issued by the Department. The Contractor shall also comply with Department of Mental Health (DMH) Letters and Information Notices issued to all Mental Health Plans as defined in Cal. Code

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Regs., tit. 9, § 1810.226 as such DMH Letters and Information Notices remain in effect unless amended, repealed, or readopted by the Department. DMH letters and Information Notices shall provide specific details of procedures established for performance of contract terms when procedures not covered in this agreement are determined to be necessary for performance under this agreement, but are not intended to change the basis and general terms of the contract.

15. Beneficiary Problem Resolution Processes

A. General Provisions

The Contractor shall represent the Contractor's position in fair hearings, as defined in Cal. Code Regs., tit. 9, § 1810.216.6, dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this contract. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

1) Pursuant to 42 C.F.R. § 438.228 and Cal. Code Regs., tit. 9, § 1850.205, the Contractor shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties, including the delivery of specialty mental health services.

2) The Contractor's beneficiary problem resolution processes shall include:

   a) A grievance process;

   b) An appeal process; and,

   c) An expedited appeal process.

3) For the grievance, appeal, and expedited appeal processes, described in 42 C.F.R. 438 Subpart F and Cal. Code Regs., tit. 9, §§ 1850.206, 1850.207 and 1850.208 respectively, the Contractor shall comply with all of the following requirements:

   a) Assure that each beneficiary has adequate information about the Contractor's problem resolution processes by taking at least the following actions:

      i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 7 of this contract.

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ii. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to Cal. Code Regs., tit. 9, § 1850.210. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain specialty mental health services.

iii. Pursuant to Cal. Code Regs., tit. 9, § 1850.205(c)(1)(C), making available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all Contractor provider sites without having to make a verbal or written request to anyone.

iv. Pursuant to 42 C.F.R. § 438.406(a)(1), giving beneficiaries any reasonable assistance in completing the forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

b) Pursuant to 42 C.F.R. § 438.406(a)(2), the Contractor shall acknowledge receipt of each grievance appeal, and request for expedited appeal to the beneficiary in writing.

c) Consistent with 42 C.F.R. § 438.402(b)(1)(ii), a beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process, if the provider consents.

d) A beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

e) At the beneficiary's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing specialty mental health services to the beneficiary requesting assistance, the Contractor shall identify another individual to assist that beneficiary.

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f) A beneficiary shall not be subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

g) Procedures for these beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information.

h) A procedure shall be included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. These issues shall be considered in the Contractor's Quality Improvement Program, as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

i) Individuals involved in any previous review or decision-making on the issue(s) presented in a problem resolution process shall not participate in making the decision on the grievance, appeal, or expedited appeal pursuant to 42 C.F.R. § 438.406(a)(3)(i).

j) The individual making the decision on the grievance, appeal, or expedited appeal shall have the appropriate clinical expertise, as determined by the Contractor, required to treat the beneficiary's condition, if the grievance concerns the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal addresses any clinical issue, including a lack of medical necessity pursuant to Title per 42, C.F.R. § 438.406(a)(3)(ii).

4) Pursuant to record keeping and review requirements in 42 C.F.R. § 438.416, and to facilitate monitoring consistent with Cal. Code Regs., tit. 9, §§1810.440(a)(5), 1850.205,1850.206, 1850.207, and 1850.208, the Contractor shall:

a) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include, but not be limited to, the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem;

b) Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log;

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c) Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal;

d) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing;

e) Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the beneficiary;

f) Notify the beneficiary, in writing, of the final disposition of the problem resolution process including the reasons for the disposition; and

g) Notify, in writing, any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

5) No provision of a Contractor's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code Section 5520.

B. Grievance Process

Consistent with 42 C.F.R. §§ 438.400, 438.402, 438.406 and Cal. Code Regs., tit. 9, § 1850.206, the grievance process shall, at a minimum:

1) Allow beneficiaries to present their grievance orally, or in writing;

2) Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Cal. Code Regs., tit. 9, § 1810.230.5; and

3) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

C. Appeal Process

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1) Consistent 42 C.F.R. § 438.408 and Cal. Code Regs., tit. 9, §§ 1850.205 and 1850.207, the appeal process shall, at a minimum:

   a) Allow a beneficiary to file an appeal orally or in writing pursuant to 42 C.F.R. § 438.402(b)(3)(ii);

   b) Pursuant to 42 C.F.R. § 438.402(b)(3)(ii), require a beneficiary who makes an oral appeal, that is not an expedited appeal, to subsequently submit the appeal in writing. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes;

   c) Pursuant to 42 C.F.R. § 438.408(b) and (c), provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an extension or the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Cal. Code Regs., tit. 9, §1810.230.5;

   d) Consistent with 42 C.F.R. § 438.408(f), inform the beneficiary of his or her right to request a fair hearing after the appeal process of the Contractor has been exhausted;

   e) Allow the beneficiary to have a reasonable opportunity to present evidence and arguments of fact or law, in person and/or in writing, in accordance with the beneficiary's election;

   f) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process, provided that there is no disclosure of the protected health information of any individual other than the beneficiary; and

   g) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

2) Pursuant to 42 C.F.R. § 438.408(e), the Contractor shall notify the beneficiary, and/or his or her representative, of the resolution of the appeal in writing. The notice shall contain:

   a) The results of the appeal resolution process;

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b) The date that the appeal decision was made;

c) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain:

i. Information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal; and

ii. Information on the beneficiary's right to continue to receive benefits while the fair hearing is pending and how to request the continuation of benefits.

3) If the decision of the appeal resolution process reverses a decision to deny, limit or delay services, the Contractor shall promptly provide or arrange and pay for the services at issue in the appeal.

D. Expedited Appeal Process

"Expedited Appeal" means an appeal, as defined in Cal. Code Regs., tit. 9, § §§ 1810.203.5 and 1810.216.2, to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal as established in Cal. Code Regs., tit. 9, § 1850.207, would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. In addition to meeting the requirements of 42 C.F.R. § 438.410(a), and Cal. Code Regs., tit. 9, §§ 1850.205, 1850.207(a), (d), (e), (f), (g), and (i), and 1850.208, the expedited appeal process shall, at a minimum:

1) Be used when the Contractor determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

2) Pursuant to 42 C.F.R. § 438.402(b)(3), allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.

3) Pursuant to 42 C.F.R. § 438.410(b), ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

4) Pursuant to 42 C.F.R. § 438.408(b)(3),resolve an expedited appeal and notify the affected parties in writing, no later than three working days after

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the Contractor receives the appeal. Pursuant to 42 C.F.R. § 438.408(c) this timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the Contractor determines that there is need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Cal. Code Regs., tit. 9, § 1810.230.5.

5) Pursuant to 42 C.F.R. § 438.408(d)(2), provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. The written notice shall meet the requirements of Section 1850.207(h).

6) Pursuant to 42 C.F.R. § 438.410(c), if the Contractor denies a request for expedited appeal resolution:

   a) Transfer the expedited appeal request to the timeframe for appeal resolution as required by Cal. Code Regs., tit. 9, § 1850.207(c).

   b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in Cal. Code Regs., tit. 9, § 1810.230.5.

E. Beneficiary Problem Resolution Processes Established by Providers

Nothing in the Cal. Code Regs., tit. 9, §§ 1850.205, 1850.206, 1850.207, 1850.208 and 1850.209 precludes a provider other than the Contractor from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the Contractor to use or exhaust the provider's processes prior to using the Contractor's beneficiary problem resolution process, unless the following conditions have been met:

1) The Contractor delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation;

2) The provider's beneficiary problem resolution process fully complies with this Section of the contract, the relevant provisions of 42 C.F.R. Subpart F, Cal. Code Regs., tit. 9, §1850.205 and § 1850.209, and depending on processes delegated, Cal. Code Regs., tit. 9, §§ 1850.206, 1850.207, and/or 1850.208; and

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3) No beneficiary is prevented from accessing the grievance, appeal or expedited appeal processes solely on the grounds that the grievance, appeal or expedited appeal was incorrectly filed with either the Contractor or the provider.

F. Fair Hearing

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, CCR, Sections 50951 and 50953 and Cal. Code Regs., tit. 9, § 1810.216.6. Fair hearings must comply with 42 C.F.R. §§ 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

1) If a beneficiary requests a State Fair Hearing, the Department (not the Contractor) shall grant the request. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or notice of action. Beneficiaries and providers shall also be informed of the following:

   a) A beneficiary may request a State Fair Hearing.

   b) The provider may request a State Fair Hearing only if the Department permits the provider to act as the beneficiary's authorized representative.

   c) The Department must permit the beneficiary to request a State Fair Hearing within a reasonable time period specified by the Department, not in excess of 90 days, from whichever of the following dates applies:

      i. From the date indicated on the Contractor's notice of action, if the Department does not require exhaustion of the Contractor-level appeal procedures and the beneficiary appeals directly to the Department for a fair hearing.

      ii. From the date indicated on the Contractor's notice of resolution, if the Department requires exhaustion of Contractor-level appeals.

2) The Department must reach its decisions within the specified timeframes:

   a) Standard resolution: within 90 days of the date the beneficiary filed the appeal with the Contractor, if the beneficiary filed initially with the Contractor (excluding the days the beneficiary took to subsequently file for a State Fair Hearing), or the date the beneficiary filed for direct access to a State Fair Hearing.

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b) Expedited resolution (if the appeal was heard first through the Contractor appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that:

i. Meets the criteria for an expedited appeal process but was not resolved using the Contractor's expedited appeal timeframes, or

ii. Was resolved wholly or partially adversely to the beneficiary using the Contractor's expedited appeal timeframes.

3) Pursuant to 42 C.F.R. § 438.408(f)(2), the parties to the State Fair Hearing include the Contractor as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

G. Expedited Fair Hearing

"Expedited Fair Hearing" means a fair hearing, as described in 42 C.F.R. § 438.410(a), and Cal. Code Regs., tit. 9, §§ 1810.216.4 and 1810.216.6, to be used when the Contractor determines, or the beneficiary and/or the beneficiary's provider certifies, that the following the timeframe for a fair hearing as established in 42 C.F.R. § 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

H. Continuation of Services Pending Fair Hearing Decision

1) A beneficiary receiving specialty mental health services shall have a right to file for continuation of specialty mental health services pending the outcome of a fair hearing pursuant to Cal. Code Regs., tit. 22., § 51014.2, and Cal. Code Regs., tit. 9, § 1850.215.

2) The Contractor shall continue to provide specialty mental health services pending the outcome of a fair hearing in accordance with Cal. Code Regs., tit. 22, § 51014.2. If the Contractor allows providers to deliver specialty mental health services for a set number of visits or a set duration of time without prior authorization, the Contractor shall continue to provide specialty mental health services pending the outcome of a fair hearing when the Contractor denies a payment authorization request from a provider requesting continuation of services beyond the number or duration permitted without prior authorization and the beneficiary files a timely request for fair hearing.

3) Before requesting a state fair hearing, the beneficiary must exhaust the Contractor's problem resolution processes as described in Cal. Code Regs., tit. 9, § 1850.205.

I. Provision of Notice of Action

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1) Consistent with 42 C.F.R. § 438.400(b) and Cal. Code Regs., tit. 9, § 1810.200 "Action," in the case of an MHP, means:

   a) A denial, modification, reduction or termination of a provider's request for MHP payment authorization of a specialty mental health service covered by the MHP.

   b) A determination by the MHP or its providers that the medical necessity criteria in Cal. Code Regs., tit. 9, §§ 1830.205(b)(1), (b)(2), (b)(3)(C), or 1830.210(a) have not been met and the beneficiary is not entitled to any specialty mental health services from the MHP.

   c) A failure by the MHP to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP; or

   d) A failure by the MHP to act within the timeframes for resolution of grievances, appeals, or the expedited appeals.

2) Pursuant to 42 C.F.R. § 438.404(a), the Notice of Action (NOA) shall be in writing and shall meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding. The Notice of Action shall contain the items specified in 42 C.F.R. § 438.404 (b) and Cal. Code Regs., tit. 9, § 1850.210.

3) The Contractor shall provide a beneficiary with an NOA when the Contractor denies or modifies a Contractor payment authorization request from a provider for a specialty mental health service to the beneficiary.

4) When the denial or modification involves a request from a provider for continued Contractor payment authorization of a specialty mental health service or when the Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with Cal. Code. Regs., tit. 22, § 51014.1.

5) A NOA is not required when a denial is a non-binding verbal description to a provider of the specialty mental health services that may be approved by the Contractor.

6) A NOA is not required when the Contractor modifies the duration of any approved specialty mental health services as long as the Contractor provides an opportunity for the provider to request Contractor payment authorization of additional specialty mental health services before the end of the approved duration of services.

7) Except as provided in subsection 6 below, a NOA is not required when the denial or modification is a denial or modification of a request for Contractor

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payment authorization for a specialty mental health service that has already been provided to the beneficiary.

8) A NOA is required when the Contractor denies or modifies a payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor.

9) The Contractor shall deny the Contractor payment authorization request and provide the beneficiary with a NOA when the Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by Cal. Code Regs., tit. 9, §§ 1820.220 or 1830.215.

10) The Contractor shall provide the beneficiary with a NOA if the Contractor fails to notify the affected parties of a grievance decision within 60 calendar days, of an appeal decision within 45 days, or of an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to Cal. Code Regs., tit. 9, §§ 1850.206, 1850.207 or 1850.208 and the Contractor failed to notify the affected parties of its decision within the extension period, the Contractor shall provide the beneficiary with a NOA.

11) The Contractor shall provide a beneficiary with a NOA if the Contractor fails to provide a specialty mental health service covered by the Contractor within the timeframe for delivery of the service established by the Contractor.

12) The Contractor shall comply with the requirements of 42 C.F.R. § 438.404(b), and Cal. Code Regs., tit. 9, § 1850.210, regarding the content of NOAs and with the following timeframes for mailing of NOAs:

    a) The written NOA issued pursuant to (1) or (6) above shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the action. A Notice of Action issued pursuant to (2) above shall be provided in accordance with the applicable timelines set forth in Cal. Code Regs., tit. 22, § 51014.1.

    b) The written NOA issued pursuant to (7) or (8) above shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

    c) The written NOA issued pursuant to subsection (9) above shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the Contractor expires.

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13) When a NOA would not be required as described in (3)-(5) above, the Contractor shall provide a beneficiary with an NOA when the Contractor or its providers determine that the medical necessity criteria in Cal. Code Regs., tit. 9, §§1830.205(b)(1),(b)(2),(b)(3)(C), or 1830.210(a) have not been met and that the beneficiary is not entitled to any specialty mental health services from the Contractor. A NOA is not required when a provider, including the Contractor acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the Contractor, including but not limited to: crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any specialty mental health service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other specialty mental health service covered by the Contractor. The NOA shall, at the election of the Contractor, be hand-delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with Cal. Code Regs., tit. 9, § 1850.210(f)(1), and shall specify the information contained in Cal. Code Regs., tit. 9, § 1850.212(b).

14) For the purpose of this Section, each reference to a Medi-Cal managed care plan in Cal. Code Regs., tit. 22, § 51014.1, shall mean the Contractor.

15) For the purposes of this Section, "medical service", as used in Cal. Code Regs., tit. 22, § 51014.1, shall mean specialty mental health services that are subject to prior authorization by a Contractor pursuant to Cal. Code Regs., tit. 9, §§ 1820.100 and 1830.100.

16) The Contractor shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to the Department.

J. Contents of a NOA

1) The NOA issued pursuant to Section I of this contract and 42 C.F.R. § 438.404(b) and Cal. Code Regs., tit. 9, §§1850.210(a)-(e) and 1850.212, shall contain the following information:

a) The action taken by the Contractor;

b) The reason for the action taken;

c) Citations to the regulations or Contractor payment authorization procedures supporting the action;

d) The beneficiary's right to file an appeal or expedited appeal with the Contractor;

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e) The circumstances under which an expedited resolution is available, and how to request it; and,

f) Information about the beneficiary's right to request a fair hearing or an expedited fair hearing, including:

i. The method by which a hearing may be obtained;

ii. A statement that the beneficiary may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

iii. An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested; and,

iv. The time limits for requesting a fair hearing or an expedited fair hearing.

2) A NOA issued pursuant to Cal. Code Regs., tit. 9, §§ 1850.210(g) and 1850.212(b), relating to denials for lack of medical necessity, shall specify the following:

a) The reason that the medical necessity criteria were not met, including a citation to the applicable regulation;

b) The beneficiary's options for obtaining care from sources other than the Contractor, if applicable;

c) The beneficiary's right to request a second opinion on the determination;

d) The beneficiary's right to file an appeal or expedited appeal with the Contractor; and,

e) The beneficiary's right to request a fair hearing or an expedited fair hearing, including:

i. The method by which a hearing may be obtained;

ii. The time period in which the request for a fair hearing or expedited fair hearing must be filed; and,

iii. That the beneficiary may be either self–represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

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K. Consistent with 42 C.F.R. § 438.404(c), the Contractor shall give notice at least 10 days before the effective date of action when the action is a termination, suspension, or reduction of previously authorized Medi-Cal-covered services, except:

1) The period of advanced notice is shortened to 5 days if probable beneficiary fraud has been verified;

2) The action shall be effective on the date of the Notice under the following circumstances:

a) The death of a beneficiary;

b) Receipt of a signed written beneficiary statement requesting service termination or giving information requiring termination or reduction of services (provided the beneficiary understands that this will be the result of supplying that information);

c) The beneficiary's admission to an institution where he or she is ineligible for further services;

d) The beneficiary's whereabouts are unknown and mail directed to him or her has no forwarding address;

e) Notice that the beneficiary has been accepted for Medicaid services by another local jurisdiction;

f) A change in the beneficiary's physician's prescription for the level of medical care; or

g) Endangerment of the safety or health of individuals in the facility; improvement in the resident's health sufficient to allow a more immediate transfer or discharge; urgent medical needs that require a resident's immediate transfer or discharge; or notice that a resident has not resided in the nursing facility for 30 days (but only in adverse actions based on NF transfers).

3) If payment is denied, the Contractor shall give notice to the beneficiary on the date of the action.

L. Pursuant to Cal. Code Regs., tit. 9, § 1810.375(a), the Contractor is required to submit to the Department a report that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition.

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16. Subcontracts

A. This provision is a supplement to provision number five (Subcontract Requirements) in Exhibit D(F) which is attached hereto as part of this agreement. As allowed by provision five in Exhibit D(F), the Department hereby, and until further notice, waives its right to prior approval of subcontracts and approval of existing subcontracts.

B. No subcontract terminates the legal responsibility of the Contractor to the Department to assure that all activities under this contract are carried out.

C. All subcontracts shall be in writing.

D. All inpatient subcontracts shall require that subcontractors maintain necessary licensing and certification.

E. Each subcontract shall contain:

1) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

2) Specification of the services to be provided.

3) Specification that the subcontract shall be governed by, and construed in accordance with, all laws and regulations, and all contractual obligations of the Contractor under this contract.

4) Specification of the term of the subcontract including the beginning and ending dates, as well as methods for amendment, termination and, if applicable, extension of the subcontract. The subcontract must be subject to full or partial termination if the subcontractor's performance is inadequate.

5) The nondiscrimination and compliance provisions of this contract as described in Exhibit E, Section 3.

6) Subcontractor's agreement to submit reports as required by the Contractor.

7) The subcontractor's agreement to make all of its books and records pertaining to the goods and services furnished under the terms of the subcontract available for inspection, examination or copying by the Department, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives. The subcontract shall also state that inspection shall occur at all reasonable times, at the subcontractor's place of business, or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record

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keeping, for a term of at least five years from the close of the state fiscal year in which the subcontract was in effect.

8) Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the Contractor.

9) Subcontractor's agreement to hold harmless both the State and beneficiaries in the event the Contractor cannot or does not pay for services performed by the subcontractor pursuant to the subcontract.

10) The subcontractor's agreement to comply with the Contractor's policies and procedures on advance directives and the Contractor's obligations for Physician Incentive Plans, if applicable based on the services provided under the subcontract.

11) A requirement that the Contractor monitors the subcontractor and the subcontractor's obligation to provide a corrective action plan if deficiencies are identified.

17. Delegation

Unless specifically prohibited by this contract or by federal or state law, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. In addition, Contractor may accept the certification of a provider by another Mental Health Plan, or by the Department, in order to meet the Contractor's obligations under Section 4. However, regardless of any such delegation to a subcontracting entity or acceptance of a certification by another MHP, Contractor shall remain ultimately responsible for adequate performance of all duties and obligations under this contract.

18. Program Integrity Requirements

A. The Contractor shall comply with the provisions of 42 C.F.R. §§ 438.604, 438.606 and 438.608, regarding the certification of accurate data submitted by the Contractor to the State and which require the Contractor to have administrative or management arrangements or procedures designed to guard against fraud and abuse.

B. The Contractor shall comply with the provisions of 42 C.F.R. § 438.610, which relate to prohibited affiliations with individuals or affiliates of individuals debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under the guidelines implementing Executive Order No. 12549.

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C. Pursuant to 42 C.F.R. § 438.214(d), the Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, or 1156 of the Social Security Act. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or the State Children's Health Insurance Program, except for emergency services.

D. The Contractor shall periodically check the Office of the Inspector General's List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List (S & I List) to prevent employment of, or payments to, any individuals or entities on those lists, and per DMH Letter Number 10-05, this must be satisfied prior to Medi-Cal certification of any individual or organizational provider. If the provider is listed on either the Office of the Inspector General's List of Excluded Individuals/Entities or the Medi-Cal S & I List, the Contractor shall not certify or pay any provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

E. Report. Pursuant to 42 C.F.R. § 455.1(a)(1), the Contractor must report fraud and abuse information to the Department.

1) If the Contractor identifies an issue or receives notification of a complaint concerning an incident of possible potential fraud or abuse, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, regarding potential fraud and/or abuse, and develop and implement corrective action, if needed. The majority of potential fraud or abuse issues are expected to be resolved at the Contractor level.

2) If the Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue is egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall report the issue to the Department for review and disposition.

3) The Department is to be notified if the Contractor discontinues a provider contract or disciplines a provider due to a fraud or abuse issue.

F. Service Verification. To assist the Department in meeting its obligation under 42 C.F.R. § 455.1(a)(2), the Contractor shall have a way to verify whether services were actually furnished to beneficiaries.

19. Disclosures

A. Disclosure of 5% or More Ownership Interest:

1) Pursuant to 42 C.F.R. § 455.104, Medicaid managed care entities must disclose certain information related to persons who have an ownership or control interest in the managed care entity, as defined in 42 C.F.R. §

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455.101. The parties hereby acknowledge that because the Contractor is a political subdivision of the State of California, there are no persons who meet such definition and therefore there is no information to disclose.

a) In the event that, in the future, any person obtains an interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by Contractor, and that interest equals at least 5% of Contractor's property or assets, then the Contractor will make the disclosures set forth in i and subsection 2(a).

i. The Contractor will disclose the name, address, date of birth, and Social Security Number of any managing employee, as that term is defined in 42 C.F.R. § 455.101. For purposes of this disclosure, Contractor may use the business address for any member of its Board of Supervisors.

ii. The Contractor shall provide any such disclosure upon execution of this contract, upon its extension or renewal, and within 35 days after any change in Contractor ownership or upon request of the Department.

2) The Contractor shall ensure that its subcontractors/network providers submit the disclosures below to the Contractor regarding the network providers' (disclosing entities') ownership and control. The Contractor's network providers must be required to submit updated disclosures to the Contractor upon submitting the provider application, before entering into or renewing the network providers' contracts, and within 35 days after any change in the subcontractor/network provider's ownership or upon request of the Department.

a) Disclosures to be Provided:

i. The name and address of any person (individual or corporation) with an ownership or control interest in the network provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;

ii. Date of birth and Social Security Number (in the case of an individual);

iii. Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);

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iv. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

v. The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and

vi. The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

3) All disclosures must be provided to the Medicaid agency.

B. Disclosures Related to Business Transactions – Contractor must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.

1) The following information must be disclosed:

a) The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,

b) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

2) Contractor must obligate Network Providers to submit the same disclosures regarding network providers' as noted under subsection 1(a) and (b) within 35 days upon request.

C. Disclosures Related to Persons Convicted of Crimes – Contractor shall submit the following disclosures to the Department regarding the Contractor's management:

1) The identity of any person who is a managing employee of the Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)

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2) The identity of any person who is an agent of the Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 C.F.R. § 455.101.

3) The Contractor shall supply the disclosures before entering into the contract and at any time upon the Department's request.

4) Network providers should submit the same disclosures to the Contractor regarding the network providers' owners, persons with controlling interest, agents, and managing employees' criminal convictions. Network providers shall supply the disclosures before entering into the contract and at any time upon the Department's request.

20. Medi-Cal Eligibility Data System (MEDS) and MEDS Monthly Extract File (MMEF) Access

The Contractor shall enter into a Medi-Cal Privacy and Security Agreement (PSA) with the Department prior to obtaining access to MEDS and the MEDS monthly extract file (MMEF). The Contractor agrees to comply with the provisions as specified in the PSA. The County Mental Health Director or his or her authorized designee shall certify annually that Contractor is in compliance with the PSA agreement. Failure to comply with the terms of the agreement will result in the termination of access to MEDS and MMEF.

21. Additional Requirements

A. Advance Directives. The Contractor shall maintain written policies and procedures on advance directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6(i)(1), (3) and (4). Any written materials prepared by the Contractor for beneficiaries shall be updated to reflect changes in state laws governing advance directives as soon as possible, but no later than 90 days after the effective date of the change. For purposes of this contract, advance directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated as defined in 42 C.F.R. § 489.100.

B. Physician Incentive Plans. The Contractor shall obtain approval from the Department prior to implementing a Physician Incentive Plan. A Physician Incentive Plan is any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any beneficiary. For purposes of this definition, the words shall have the meanings set forth in 42 C.F.R. § 422.208(a). The Department shall approve the Contractor's request only if the proposed Physician Incentive Plan complies with all applicable federal and state regulations.

1) Pursuant to 42 C.F.R. § 438.6(h), the Contractor shall comply with the requirements set forth in 42 CFR §§ 422.208 and 422.210.

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2) The Contractor may operate a Physician Incentive Plan only if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

3) When seeking approval from the Department for its Physician Incentive Plan, the Contractor will disclose the following:

   a) Whether services not furnished by physician/group are covered by incentive plan. No further disclosure required if the Physician Incentive Plan does not cover services not furnished by physician/group;

   b) The type of incentive arrangement, e.g. withhold, bonus, capitation;

   c) The percentage of funds withheld or bonus provided (if applicable);

   d) The size of the panel, and, if patients are pooled, the approved method used for pooling; and,

   e) If the physician/group is at substantial financial risk, proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

4) If a physician or physician group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual beneficiary surveys.

5) The Contractor shall provide information on its Physician Incentive Plan to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a Physician Incentive Plan).

6) If required to conduct beneficiary survey, survey results shall be disclosed to the Department and, upon request, to beneficiaries, per the Social Security Act (SSA) 1903(m)(2)(A)(x); 42 C.F.R. §§ 422.208; 422.210;438.6(h); and SSA 1876(i)(8)(A)(ii)(II).

C. Sharing of Information with Beneficiaries. The Contractor shall not prohibit nor otherwise restrict, a licensed, waivered, or registered professional, as defined in Cal. Code Regs., tit. 9, §§ 1810.223 and 1810.254, who is acting within the lawful scope of practice (pursuant to 42 C.F.R. § 438.102(a)(1)), from advising or advocating on behalf of a beneficiary for whom the provider is providing mental health services for any of the following:

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1) The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2) Information on the beneficiary needs in order to decide among all relevant treatment options;

3) The risks, benefits, and consequences of treatment not receiving treatment ; and

4) The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

D. Limitation on Services for Moral or Religious Grounds. Pursuant to 42 C.F.R. § 438.102(a)(2), the Contractor shall not be required to provide, reimburse for, or provide coverage of, a counseling or referral service if the Contractor objects to the service on moral or religious grounds.

E. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

a) To the Department:

a) Prior to executing this contract;

b) Whenever it adopts the policy during the term of the contract;

b) Consistent with the provisions of 42 C.F.R. § 438.10:

a) To potential beneficiaries before and during enrollment; and

b) To beneficiaries within 90 days after adopting the policy with respect to any particular service.

F. Beneficiary Liability for Payment. Pursuant to Cal. Code Regs., tit. 9, § 1810.365, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not submit a claim to, or 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. Consistent with 42 C.F.R. § 438.106, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which the State does not pay the Contractor, for costs of covered services for which the State or the Contractor does not pay the

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Contractor's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

G. Health Information System. Pursuant to 42 C.F.R. § 438.242 and consistent with Cal. Code Regs., tit. 9, § 1810.376, the Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances, and appeals.

1) The Contractor's health information system shall, at a minimum:

a) Collect data on beneficiary and provider characteristics as specified by the Department, and on services furnished to beneficiaries as specified by the Department;

b) Ensure that data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data;

ii. Screening the data for completeness, logic, and consistency; and

iii. Collecting service information in standardized formats to the extent feasible and appropriate.

c) Make all collected data available to the Department and, upon request, to CMS.

2) Consistent with Cal. Code Regs., tit. 9, § 1810.376(c), the Contractor's health information system is not required to collect and analyze all elements in electronic formats.

H. Cost Sharing. Pursuant to 42 C.F.R. § 438.108, any cost sharing imposed on Medicaid beneficiaries shall be in accordance with 42 C.F.R. §§ 447.50 through 447.60.

22. Quality Management (QM) Program

A. The Contractor's Quality Management (QM) Program shall improve Contractor's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

B. The Contractor shall have a written description of the QM Program which clearly defines the QM Program's structure and elements, assigns responsibility to

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appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Cal. Code Regs., tit. 9, § 1810.440(a)(6) and 42 C.F.R. § 438.240(e).

C. The QM Program shall conduct performance monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.

D. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.

E. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by 42 C.F.R. § 438.240(b)(3).

F. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:

1) Surveying beneficiary/family satisfaction with the Contractor's services at least annually;

2) Evaluating beneficiary grievances, appeals and fair hearings at least annually; and

3) Evaluating requests to change persons providing services at least annually.

4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

G. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

H. The Contractor shall implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.

I. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.

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J. The Contractor shall have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan shall include:

1) Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416;

2) Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;

3) A description of completed and in-process QM activities, including performance improvement projects. The description shall include:

a) Monitoring efforts for previously identified issues, including tracking issues over time;

b) Objectives, scope, and planned QM activities for each year; and,

c) Targeted areas of improvement or change in service delivery or program design.

4) A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care; and

5) Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Cal. Code Regs., tit. 9, § 1810.410.

23. Quality Improvement (QI) Program

A. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries.

B. The Contractor shall establish a QI Committee to review the quality of specialty mental health services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken.

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C. The QI Program shall be accountable to the Contractor's Director as described in Cal. Code Regs., tit. 9, § 1810.440(a)(1).

D. Operation of the QI program shall include substantial involvement by a licensed mental health staff person, as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(4).

E. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program, as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(2)(A-C).

F. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 C.F.R. § 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

G. QI activities shall include:

1) Collecting and analyzing data to measure against the goals, or prioritized areas of improvement that have been identified;

2) Identifying opportunities for improvement and deciding which opportunities to pursue;

3) Identifying relevant committees internal or external to the Contractor to ensure appropriate exchange of information with the QI Committee;

4) Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;

5) Designing and implementing interventions for improving performance;

6) Measuring effectiveness of the interventions;

7) Incorporating successful interventions into the Contractor's operations as appropriate; and

8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

24. Utilization Management (UM) Program

A. The Utilization Management Program shall be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Cal. Code Regs., tit. 9, § 1810.440(b)(1)-(3).

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Service, Administrative and Operational Requirements

B. The Utilization Management (UM) Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.

C. The Contractor shall implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Contractor's delivery system.

D. The Contractor shall implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the Contractor's 24 hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

25. Practice Guidelines

The Contractor shall comply with 42 C.F.R. § 438.236(b) and Cal. Code Regs., tit. 9, § 1810.326 which requires the adoption of practice guidelines.

A. Such guideline shall meet the following requirements:

1) They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;

2) They consider the needs of the beneficiaries;

3) They are adopted in consultation with contracting health care professionals; and

4) They are reviewed and updated periodically as appropriate.

B. Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

C. Contractor shall take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines.

Exhibit A Attachment II
Definitions

The definitions contained in Cal. Code Regs., tit. 9, § 1810.100 et. seq. shall apply in this contract.

A. "Beneficiary" means a Medi-Cal recipient who is currently receiving services from the Contractor.

B. "Contractor" means El Dorado County Health and Human Services Agency.

C. "Covered Specialty Mental Health Services" means mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, psychiatric health facility services, and targeted case management as described in California's Medicaid State Plan and as defined in Cal. Code Regs., tit. 9, § 1810.247, to the extent described in Cal. Code Regs., tit. 9, § 1810.345. Covered Specialty Mental Health Services also include psychiatric inpatient hospital services as defined in Cal. Code Regs., tit. 9, § 1810.238, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services as defined in Cal. Code Regs., tit. 9, § 1810.215. Psychiatric nursing facility services are not included.

D. "Department" means the California Department of Health Care Services (DHCS).

E. "Director" means the Director of DHCS.

F. "HHS" means the United States Department of Health and Human Service

G. "PIHP" means Prepaid Inpatient Health Plan as described in 42 C.F.R. § 438.2. A PIHP is an entity that:

1) Provides medical services to beneficiaries under contract with the Department of Health Care Services, and on the basis of prepaid capitation payments, or other payment arrangement that does not use state plan rates;

2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and

3) Does not have a comprehensive risk contract.

H. "Subcontract" means an agreement entered into by the Contractor with any of the following:

1) A provider of specialty mental health services who agrees to furnish covered services to beneficiaries.

Exhibit A Attachment II
Definitions

2) Any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this contract.

Exhibit B
Budget Detail and Payment Provisions

1. Payment Provisions

This program may be funded using one or more of the following funding sources: funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, funds from the Mental Health Services Fund, and any other funds from which the Controller makes distributions to the counties in compliance with applicable statute and regulations including Welf. & Inst. Code §§ 5891, 5892 and 14705(a)(2). These funding sources may be used by the Contractor to pay for services and then certify as public expenditures in order to be reimbursed federal funds.

2. Budget Contingency Clause

This provision is a supplement to provision number nine (Federal Contract Funds) in Exhibit D(F) which is attached hereto as part of this agreement.

A. Federal Budget

If federal funding for FFP reimbursement in relation to this contract is eliminated or substantially reduced by Congress, the Department and the Contractor each shall have the option either to cancel this contract or to propose a contract amendment to address changes to the program required as a result of the elimination or reduction of federal funding.

B. Delayed Federal Funding

Contractor and Department agree to consult with each other on interim measures for program operation that may be required to maintain adequate services to beneficiaries in the event that there is likely to be a delay in the availability of federal funding.

3. Federal Financial Participation

Nothing in this contract shall limit the Contractor's ability to submit claims for appropriate FFP reimbursement based on actual, total fund expenditures for any covered services or quality assurance, utilization review, Medi-Cal Administrative Activities and/or administrative costs. In accordance the Welf. & Inst. Code § 14705(c), the Contractor shall ensure compliance with all requirements necessary for Medi-Cal reimbursement for these services and activities. Claims for FFP reimbursement shall be submitted by the Contractor to the Department for adjudication throughout the fiscal year. Pursuant to the Welf. & Inst. Code § 14705(d), the Contractor shall certify to the state that it has incurred public expenditures prior to requesting the reimbursement of federal funds.

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4. Cost Reporting

A. The Contractor shall submit a fiscal year-end cost report no later than December 31 following the close of each fiscal year unless that date is extended by the Department, in accordance with the Welf. & Inst. Code § 14705(c), and/or guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the Contractor's chief financial officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to, the Contractor's chief financial officer, or (3) the Contractor's auditor-controller, or equivalent. The cost report shall include both Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual which can be accessed through the Department's Information Technology Web Services (ITWS) for the applicable year, as well as any instructions that are incorporated by reference thereto; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures developed under the Welf. & Inst. Code § 14171.

B. In accordance with Welf. & Inst. Code § 5655 , the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department, in accordance with Welf.& Inst. Code § 14712(e), may withhold payments of additional funds until the cost report that is due has been submitted.

C. Upon receipt of an amended cost report, which includes reconciled units of service, and a certification statement that has been signed by the Contractor's Mental Health Director and one of the following: 1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county's auditor controller, or equivalent, the Department shall preliminarily settle the cost report. After completing its preliminary settlement, the Department shall so notify the Contractor if additional FFP is due to the Contractor. The Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority. If funds are due to the State, the Department shall invoice the Contractor and the Contractor shall return the overpayment to the Department.

5. Audits and Recovery of Overpayments

A. Pursuant to Welf. & Inst. Code § 14707, in the case of federal audit exceptions, the Department will follow federal audit appeal processes unless the Department, in

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Budget Detail and Payment Provisions

consultation with the California Mental Health Director's Association, determines that those appeals are not cost beneficial.

1) Whenever there is a final federal audit exception against the State resulting from a claim for federal funds for an expenditure by individual counties that is not federally allowable, the department may offset federal reimbursement and request the Controller's office to offset the distribution of funds to the Contractor from the Mental Health Subaccount, the Mental Health Equity Subaccount and the Vehicle License Collection Account of the Local Revenue Fund; funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011; and any other mental health realignment funds from which the Controller makes distributions to the counties by the amount of the exception. The Department shall provide evidence to the Controller that the county had been notified of the amount of the audit exception no less than 30 days before the offset is to occur.

2) The Department will involve the Contractor in developing responses to any draft federal audit reports that directly impact the county.

B. Pursuant to Welf. & Inst. Code § 14718(b)(2), the Department may offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the Contractor.

1) The Department may offset the amount of any state disallowance, audit exception, or overpayment for fiscal years through and including 2010-11 against subsequent claims from the Contractor.

2) Offsets may be done at any time, after the department has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the mental health plan.

3) The maximum withheld amount shall be 25 percent of each payment as long as the Department is able to comply with the federal requirements for repayment of FFP pursuant 42 United States Code (U.S.C.) §1396b(d)(2)). The Department may increase the maximum amount when necessary for compliance with federal laws and regulations.

C. Pursuant to the Welf. & Inst. Code § 14170 , cost reports submitted to the Department are subject to audit in the manner and form prescribed by the Department. The year-end cost report shall include both Contractor's costs and the costs of its subcontractors, if any. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. In accordance with the Welf. & Inst. Code § 14170 , any audit of Contractor's cost report shall occur within three years of the date of receipt by the Department of the final cost report with signed certification by the Contractor's Mental Health Director and one of the following: (1) the Contractor's Chief

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Budget Detail and Payment Provisions

Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county auditor controller, or equivalent. Both signatures are required before the cost report shall be considered final. For purposes of this section, the cost report shall be considered audited once the Department has informed the Contractor of its intent to disallow costs on the cost report, or once the Department has informed the Contractor of its intent to close the audit without disallowances.

D. If the adjustments result in the Department owing FFP to the Contractor, the Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority.

6. Claims Adjudication Process

A. In accordance with the Welf. & Inst. Code §14705(c), claims for federal funds in reimbursement for services shall comply with eligibility and service requirements under applicable federal and state law.

B. The Contractor shall certify each claim submitted to the Department in accordance with Cal. Code Regs., tit. 9, § 1840.112 and 42 C.F.R. § 433.51, at the time the claims are submitted to the Department. The Contractor's Chief Financial Officer or his or her equivalent, or an individual with authority delegated by the county auditor-controller, shall sign the certification, declaring, under penalty of perjury, that the Contractor has incurred an expenditure to cover the services included in the claims to satisfy the requirements for FFP. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification, declaring, under penalty of perjury that, to the best of his or her knowledge and belief, the claim is in all respects true, correct, and in accordance with the law and meets the requirements of Cal. Code Regs., tit. 9, § 1840.112(b). The Contractor shall have mechanisms that support the Mental Health Director's certification, including the certification that the services for which claims were submitted were actually provided to the beneficiary. If the Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 C.F.R. § 438.604.

C. Claims not meeting federal and/or state requirements shall be returned to Contractor as not approved for payment, along with a reason for denial. Claims meeting all Health Insurance Portability and Accountability Act (HIPAA) transaction requirements and any other applicable federal or state privacy laws or regulations and certified by the Contractor in accordance with Cal. Code Regs., tit. 9, § 1840.112, shall be processed for adjudication.

D. Good cause justification for late claim submission is governed by applicable federal and state laws and regulations and is subject to approval by the Department.

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Budget Detail and Payment Provisions

E. In the event that the Department or the Contractor determines that changes requiring a change in the Contractor's or Department's obligation must be made relating to either the Department's or the Contractor's claims submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated requirements and impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.

F. The Contractor shall comply with Cal. Code Regs., tit. 9, § 1840.304, when submitting claims for FFP for services billed by individual or group providers. The Contractor shall submit service codes from the Health Care Procedure Coding System (HCPCS) published in the most current Mental Health Medi-Cal billing manual.

7. Payment Data Certification

Contractor shall certify the data it provides to the Department to be used in determining payment of FFP to the Contractor, in accordance with 42 C.F.R. §§ 438.604 and 438.606.

8. System Changes

In the event changes in federal or state law or regulations, including court decisions and interpretations, necessitate a change in either the fiscal or program obligations or operations of the Contractor or the Department, or a change in obligation for the cost of providing covered services the Department and the Contractor agree to negotiate, pursuant to the Welf. & Inst. Code § 14714(c) regarding (a) changes required to remain in compliance with the new law or changes in existing obligations, (b) projected programmatic and fiscal impacts, (c) necessary contract amendments. To the extent that contract amendments are necessary, the parties agree to act to ensure appropriate amendments are made to accommodate any changes required by law or regulation.

9. Administrative Reimbursement

A. The Contractor may submit claims for reimbursement of Medical Administrative Activities (MAA) pursuant to Welf. & Inst. Code § 14132.47. The Contractor shall not submit claims for MAA unless it has submitted a claiming plan to the Department which was approved by the Department and is effective during the quarter in which the costs being claimed were incurred. In addition, the Contractor shall not submit claims for reimbursements of MAA that are not consistent with the Contractor's approved MAA claiming plan. The Contractor shall not use the relative value methodology to report its MAA costs on the year-end cost report. Rather, the Contractor shall calculate and report MAA units on the cost report by multiplying the amount of time (minutes, hours, etc.) spent on MAA activities by the

Exhibit B
Budget Detail and Payment Provisions

salary plus benefits of the staff performing the activity and then allocating indirect administrative and other appropriately allocated costs.

B. Pursuant to the Welf. & Inst. Code § 14711(c), administrative costs shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medicaid state plans and waivers and shall be limited to 15 percent of the total actual cost of direct client services. The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative costs.

10. Notification of Request for Contract Amendment

In addition to the provisions in Exhibit E, Additional Provisions, both parties agree to notify the other party whenever an amendment to this contract is to be requested so that informal discussion and consultation can occur prior to a formal amendment process.