DMH RULEMAKING

MEDI-CAL
MHP CONTRACTUAL OBLIGATIONS

LIST OF SUPPORTING DOCUMENTS DMH RELIED UPON

MHP Boilerplate Contract (ending June 2009)

http://www.dmh.ca.gov/Laws_and_Regulations/docs/MHP_06-09_Contract/Boilerplatecontract.pdf

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EXHIBIT A

Scope of Work

July 1, 2006 – June 30, 2009

1. The Contractor agrees to provide to the Department of Mental Health the services described herein: Provide specialty mental health services to Medi-Cal beneficiaries of «County» County within the scope of services defined in this contract.

2. The services shall be performed at appropriate sites as described in this contract.

3. The services shall be provided at the times required by this contract.

4. The project representatives during the term of this agreement will be:

Department of Mental Health County Operations «CO_Liaison» 916-«CO_Phone» (Phone) 916-654-5591 (Fax)	«MHP_Name» «FirstName» «LastName»«Suffix», «Title» «Phone1» (Phone) «FAX» (Fax)

Direct all inquiries to:

Department of Mental Health County Operations Section 1600 9th Street, Room 100 Sacramento, CA 95814	«MHP_Name» «FirstName» «LastName»«Suffix», «Title» «AddressLine1» «AddressCity», CA «AddressZIP»

Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this contract.

5. See Exhibit A, Attachments 1, 2, and 3, which are made part of this contract, for a detailed description of the work to be performed.

EXHIBIT A – ATTACHMENT 1

Service Delivery, Administrative and Operational Requirements

A. Provision of Services

The Contractor shall provide, or arrange and pay for, all medically necessary covered services to beneficiaries, as defined for the purposes of this contract, of «County» County.

The Contractor shall furnish all medically necessary covered services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under the regular Medi-Cal program, which includes Short-Doyle/Medi-Cal services. The Contractor shall ensure that all medically necessary covered 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 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 Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

The Contractor shall make all medically necessary covered services available in accordance with Title 9, CCR, Sections 1810.345 and 1810.405 with respect to:

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

2. The availability of services to meet beneficiaries' urgent conditions as defined in Title 9, CCR, Section 1810.253, 24 hours a day, 7 days a week

3. Timeliness of routine services as determined by the Contractor to be sufficient to meet beneficiaries' needs.

The Contractor shall provide second opinions in accordance with Title 9, CCR, Section 1810.405.

The Contractor shall provide out-of-plan services in accordance with Title 9, CCR, Section 1830.220 and Section 1810.365. The timeliness standards specified in the paragraphs numbered 1, 2 and 3 above apply to out-of-plan services as well as in-plan services.

The Contractor shall provide for beneficiary choice of the person providing services to the extent feasible in accordance with Title 9, CCR, Section 1830.225.

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 grounds that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. For services provided pursuant to Section C, the Contractor shall consider the following ICD-9 diagnoses codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use DSM IV.

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

B. Availability and Accessibility of Service

The Contractor shall ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis. At a minimum, the Contractor shall ensure an adequate number of providers by considering:

1. The anticipated number of Medi-Cal clients

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

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

4. The number of contract providers not accepting new Medi-Cal clients

5. The geographic location of providers considering distance, travel time, means of transportation ordinarily used by Medi-Cal clients, and physical access for disabled clients.

The Contractor shall require that contract providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the provider also serves enrollees of a commercial health plan, or that 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, if the provider serves only Medi-Cal clients.

Whenever there is a change in the Contractor's operation that would require a change in services or providers by 25 percent or more of the Contractor's beneficiaries who are receiving services from the Contractor or a reduction of an average of 25 percent or more in provider rates for providers of outpatient mental health services that are not reimbursed under the Short-Doyle/Medi-Cal cost reimbursement process, the Contractor shall provide documentation to DMH, in the format provided by DMH, that demonstrates, in accordance with the requirements of this contract, that the range of specialty mental health services offered by the Contractor are adequate for the anticipated number of beneficiaries to be served by the Contractor, and that the Contractor's providers, including employees of the Contractor and subcontracting providers, are sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries to be served by the Contractor.

C. Emergency Psychiatric Condition Reimbursement

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.

Title 42, CFR, Section 438.114(a) provides the following definitions: "Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious

dysfunction of any bodily organ or part. Emergency services means covered inpatient and outpatient services that are as follows: (1) Furnished by a provider that is qualified to furnish these services under this title. (2) Needed to evaluate or stabilize an emergency medical condition." The Contractor's responsibilities for emergency psychiatric conditions under this section operationalize these definitions in psychiatric terms. To the extent that there is a conflict between the definitions in Title 42, CFR, Section 438.114 and the Contractor's obligations as described in this section, the federal regulation shall prevail as provided in Exhibit E, Section C.

Notwithstanding Title 9, CCR, Section 1820.225, the Contractor shall apply the prudent layperson standard in determining coverage of services to treat a beneficiary's emergency psychiatric condition. Application of the prudent layperson standard means that the Contractor shall not deny reimbursement for emergency room services covered by the Contractor if a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention for a condition covered by the Contractor to result in a danger to self or others or an immediate inability to utilize food, shelter or clothing. In addition the Contractor shall not deny reimbursement for covered services when a representative of the Contractor instructs a beneficiary to seek emergency services.

Notwithstanding Title 9, CCR, Section 1820.225, effective with dates of services on or after August 13, 2003, the Contractor shall not deny treatment authorization requests (TARs) for psychiatric hospital inpatient services provided by a hospital that is not under contract to the Contractor or a hospital that is licensed as an acute psychiatric hospital for the hospital's failure to notify the Contractor of an emergency admission as required by Title 9, CCR, Section 1820.225(d)(1), which provides that TARs shall be approved when a hospital notifies the Point of Authorization within 24 hours of admission of a beneficiary to the hospital or within the time required by contract. The Contractor may deny such TARs for failure of timely notification only if the notification is provided more than 10 calendar days from the presentation for emergency services.

Notwithstanding Title 9, CCR. Section 1830.215 and any timelines established by the Contractor for submission of MHP payment authorization requests for acute psychiatric inpatient hospital professional services as defined in Title 9, CCR, Section 1810.237.1, the Contractor shall not deny an MHP payment authorization request for such services provided to a beneficiary with an emergency psychiatric condition for failure of timely notification or failure to meet MHP payment authorization timelines unless the notification is provided more than 10 calendar days from the presentation for emergency services.

D. Organizational and Administrative Capability

The Contractor shall have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This shall include as a minimum the following:

1. Designated persons, qualified by training or experience, to be responsible for the provision of covered services, authorization responsibilities and quality management duties.

2. Beneficiary problem resolution processes.

3. Provider problem resolution and appeal processes.

4. Data reporting capabilities sufficient to provide necessary and timely reports to the Department.

5. Financial records and books of account maintained, using a generally accepted method of accounting, which fully disclose the disposition of all Medi-Cal program funds received.

E. Quality Management

The Contractor shall implement a Quality Management Program in accordance with Title 9, CCR, Section 1810.440 and Appendix A (consisting of five pages) and Appendix B (consisting of three pages), which are incorporated herein by reference, for evaluating the appropriateness, including over utilization and underutilization of services, and quality of the covered services provided to beneficiaries. References to the mental health plan (MHP) in Appendices A and B are references to the Contractor. The Contractor shall provide the Department with reports generated through the Quality Management Program on request. The Contractor shall also submit timely claims to the Department that are certified in accordance with Title 9, CCR, Section 1840.112 to enable the Department to measure the Contractor's performance.

The Contractor shall ensure that all covered services delivered by organizational providers are provided under the direction of a physician; a licensed/waivered psychologist; a licensed/registered/waivered social worker; a licensed/ registered/waivered marriage and family therapist; or a registered nurse.

The Contractor shall provide the Department with information on the design, progress and outcome of the study of Latino access if required by Exhibit A, Attachment 1, Section E, of the Contractor's Fiscal Year 2002-03 contract with the Department, upon request.

F. Beneficiary Records

The Contractor shall maintain at a site designated by the Contractor for each beneficiary who has received services a legible record kept in detail consistent with Appendix C (consisting of five pages), which is incorporated herein by reference, and good professional practice which permits effective quality management processes and external operational audit processes, and which facilitates an adequate system for

follow-up treatment. References to the client in Appendix C are references to beneficiaries who have received services through the Contractor. If a beneficiary receives only psychiatric inpatient hospital services, the Contractor need not maintain a record for the beneficiary in addition to the record maintained by the facility, provided the Contractor and appropriate oversight entities have access to the facility's record as provided in Exhibit E, Section G, Item 4,g.

G. Review Assistance

The Contractor shall provide any necessary assistance to the Department in its conduct of facility inspections, and operational reviews of the quality of care being provided to beneficiaries, including providing the Department with any requested documentation or reports in advance of a scheduled on site review. The Contractor shall also provide any necessary assistance to the Department and the External Quality Review Organization contracting with the Department in the annual external quality review of the quality of care, quality outcomes, timeliness of, and access to, the services being provided to beneficiaries under this contract. Contractor shall correct deficiencies as identified by such inspections and reviews according to the time frames delineated in the resulting reports.

H. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan for Consolidation of Medi-Cal Specialty Mental Health Services pursuant Title 9, CCR, Section 1810.310 as approved by the Department, including the administration of beneficiary problem resolution processes as required by Title 9, CCR, Section 1850.205 through 1850.208. The Contractor shall obtain written approval from the Department prior to making any changes to the Implementation Plan as approved by the Department, except that changes in the Implementation Plan as a result of the implementation of the federal Medicaid managed care regulations that were effective August 13, 2002 shall not constitute a change in the Implementation Plan during the term of the contract. The Contractor may implement the changes after 30 calendar days if no notice is received from the Department, as provided in Title 9, CCR, Section 1810.310.

I. Memorandum of Understanding with Medi-Cal Managed Care Plans

The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with Title 9, CCR, Section 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.

J. Cultural Competence Plan

The Contractor shall comply with the provisions of the Contractor's Cultural Competence Plan submitted in accordance with Title 9, CCR, Section 1810.410, and approved by the Department. The Contractor shall comply with any changes to Cultural Competence Plan requirements and standards for cultural and linguistic competence established by the Department to be effective during the term of the contract. The Contractor shall provide an update on the Cultural Competence Plan as required by Title 9, CCR, Section 1810.410(d) in a format to be determined by the Department.

K. Provider Selection and Certification

Provider Selection and Certification—General

The Contractor shall comply with Title 9, CCR, Section 1810.435 in the selection of providers and shall review its providers for continued compliance with standards at least once every three years, except as otherwise provided in this contract. In addition, the Contractor shall:

1. Include in its written provider selection policies and procedures a provision that practitioners shall not be excluded solely because of the practitioners' type of license or certification;

2. 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; and

3. Not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Certification of Organizational Providers

The Contractor shall certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Appendix D (consisting of three pages), which is herein incorporated by reference, prior to the date on which the provider begins to deliver services under the contract, and once every three years after that date, except as provided in Appendix D. The on site review required by Title 9, CCR, Section 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.

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 the date the provider requested certification in accordance with the Contractor's certification procedures, the date the site was operational or 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.

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.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the sites operated by an organizational provider to facilitate the claiming of federal financial participation by the Contractor and the Department's tracking of that information.

L. Recovery from Other Sources or Providers

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. The moneys recovered are retained by the Contractor; however, contractor claims for federal financial participation for services provided to beneficiaries under this contract shall be reduced by the amount recovered. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming federal financial participation for services provided to beneficiaries with other coverage under this contract as described in DMH Letter No. 95-01, dated January 31, 1995, or subsequent DMH Letters on this subject.

M. Third-Party Tort and Casualty Liability Insurance

The Contractor shall make no claim for recovery of the value of covered services rendered to a beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance including workers' compensation awards and uninsured motorists coverage. The Contractor shall identify and notify the State Department of Health Services of cases in which an action by the beneficiary involving the tort or casualty liability of a third party could result in recovery by the recipient of funds to which the State Department of Health Services has lien rights. Such cases shall be referred to the State Department of Health Services within 10 days of discovery. To assist the State Department of Health Services in exercising

its responsibility for such recoveries, the Contractor shall meet the following requirements:

If the State Department Health Services requests payment information and/or copies of paid invoices/claims for covered services to a beneficiary, the Contractor shall deliver the requested information within 30 days of the request. 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 paid to subcontracted providers or out of plan providers for similar services.

Information to be delivered shall contain the following data items:

4. Beneficiary name.
5. Full 14 digit Medi-Cal number.
6. Social Security Number.
7. Date of birth.
8. Contractor name.
9. Provider name (if different from the Contractor)
10. Dates of service.
11. Diagnosis code and/or description of illness.
12. Procedure code and/or description of services rendered.
13. Amount billed by a subcontractor or out of plan provider to the Contractor (if applicable).
14. Amount paid by other health insurance to the Contractor or subcontractor.
15. Amount and date paid by the Contractor to subcontractor or out of plan provider (if applicable).
16. Date of denial and reasons (if applicable).

The Contractor shall identify to the State Department of Health Services 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.

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

Information reported to the State Department of Health Services pursuant to this Section shall be sent to: State Department of Health Services, Third Party Liability Branch, 1500 Capitol, Suite 320, Sacramento, California 95814.

N. Financial Resources

The Contractor shall maintain adequate financial resources to carry out its obligation under this contract.

The Contractor shall have sufficient funds on deposit with the Department in accordance with Section 5778(i), W&I Code as the matching funds necessary for federal financial participation to ensure timely payment of claims for inpatient services and associated administrative days if applicable.

O. Financial Report

The Contractor shall report the unexpended funds allocated pursuant to Exhibit B to the Department, using methods and procedures established by the Department, if payments under this contract exceed the cost of covered services, utilization review and administration. The Contractor shall not be required to return any excess to the Department.

P. Books and Records

The Contractor shall maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records shall disclose 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 eligible to receive covered services, the manner in which the Contractor administered its daily business, and the cost thereof.

Such books and records shall include, but are not limited to, all physical records originated or prepared pursuant to the 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 duly notified that the Department, DHS, 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, whichever is later.

The Contractor agrees to place in each of its subcontracts, which are in excess of $10,000 and utilize State funds, a provision that: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7)." The Contractor shall also be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

Q. 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 beneficiaries' mental health care. 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, 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.

R. Department Policy Letters

The Contractor shall comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9, CCR, Section 1810.226. Policy letters shall provide specific details of procedures established by the Department 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.

S. Delegation

The Contractor shall ensure that any duties and obligations of the Contractor under this contract that are delegated to subcontracting entities are delegated to entities with the ability to perform the activities to be delegated and meet the requirements of this contract and any applicable federal or state laws and regulations. The Contractor may delegate any duty or obligation under this contract unless delegation is specifically prohibited by this contract or by applicable federal or state laws and regulations. The Contractor may accept the certification of a provider by another Mental Health Plan or by the Department to meet the Contractor's obligations under Section K. The Department shall hold the Contractor responsible for performance of the Contractor's duties and obligations under this contract whether or not the duty or obligation is delegated to a subcontractor or another Mental Health Plan.

T. Fair Hearings

The Contractor shall represent the Contractor's position in fair hearings (as defined in Title 9, CCR, Section 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.

U. Crosswalk between Provider Coding System

The Contractor shall comply with Title 9, CCR, Section 1840.304 when submitting claims for federal financial participation for services billed by individual or group providers using service codes from the Health Care Procedure Coding System (HCPCS). The Contractor shall follow the table issued by the Department as an All County Mental Health Directors Letter dated January 5, 1999.

V. Beneficiary Brochure and Provider Lists

The Contractor shall be responsible for the production and update of its booklet and provider list pursuant to Title 42, CFR, Section 438.10, Title 9, CCR, Section 1810.360, and Exhibit A, Attachment 2, Section A starting July 1, 2006.

The Contractor shall ensure that the Contractor's general program literature used to assist beneficiaries in accessing services including, but not limited to, the booklet required by Title 9, CCR, Section 1810.360(d), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and mental health education materials used by the Contractor are available in the threshold languages of the County.

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 Title 9, CCR, Sections 1810.360 and 1810.110.

The Contractor shall comply with the following guidelines to ensure continued compliance with Federal and State requirements. The Contractor shall:

1. Not make changes to any of the statewide section content of the booklet unless directed to do so by the Department;

2. Ensure that if the Contractor makes any changes to the English version of the booklet that these changes are also included in the county's threshold languages and made available in alternate formats;

3. Produce written materials in a format that is easily understood and;

4. Ensure that the booklet includes the current toll free telephone number(s) that provides linguistic capabilities and is available twenty-four hours a day, seven days a week.

The Contractor shall ensure that provider directories continue to:

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 alternatives and options for cultural/linguistic services and;

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

When there is a change 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.

W. Requirements for Day Treatment Intensive and Day Rehabilitation

1. Authorization and Service Requirements

   The Contractor shall require providers to request an initial mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, from the Contractor for day treatment intensive and for day rehabilitation. Provider as used in this section includes Contractor staff. The Contractor shall require providers to request MHP payment authorization from the Contractor in advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week. The Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive at least every three months and day rehabilitation at least every six months. The Contractor's MHP payment authorization function shall meet the criteria of Exhibit A, Attachment 2, Section B, except that the Contractor shall not delegate the MHP payment authorization function to providers. In the event that the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization function does not include Contractor staff involved in providing day treatment intensive or day rehabilitation.

The Contractor shall require providers to request initial MHP payment authorization from the Contractor for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic behavioral services as described in DMH Letter No. 99-03, that will be provided on the same day that day treatment intensive or day rehabilitation is being provided to the beneficiary. The Contractor shall require the providers of these services to request MHP payment authorization from the Contractor for continuation of these services on the same cycle required for continuation of the concurrent day treatment intensive or day rehabilitation for the beneficiary. The Contractor shall not delegate the MHP payment authorization function to the provider of day treatment intensive or day rehabilitation or the provider of the additional services.

2. In addition to meeting the requirements of Title 9, CCR, Sections 1840.318, 1840.328, 1840.330, 1840.350, and 1840.352, the Contractor shall require that providers of day treatment intensive and day rehabilitation include the following minimum service components in day treatment intensive or day rehabilitation:

    a. Community meetings, which mean meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu that may, but are not required to be part of the continuous therapeutic milieu; actively involve staff and clients; for day treatment intensive, include a staff person whose scope of practice includes psychotherapy; for day rehabilitation, include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist; address relevant items including, but not limited to what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up.

    b. A therapeutic milieu, which means a therapeutic program that is structured by the service components described in subsections 1) and 2) below with specific activities being performed by identified staff; takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program); includes staff and activities that teach, model and reinforce constructive interactions; includes peer and staff feedback to clients on

strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; 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.

The therapeutic milieu service components described in subsections 1) and 2) below shall be made available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. (For example, a full-day program that operates five days per week would need to provide a total of 15 hours for the week; a full-day program that operates for seven days a week would need to provide a total of 21 hours for the week.)

3. Day rehabilitation shall include:

   a. Process groups, which are groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

   b. Skill building groups, which are groups in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

   c. Adjunctive therapies, which are non-traditional therapies in which both staff and clients participate that utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

4. Day treatment intensive shall include:

a. Skill building groups and adjunctive therapies as described in subsection 3, b and c above. Day treatment intensive may also include process groups as described in subsection 3, a above.

b. Psychotherapy, which means the use of psychosocial methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, 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.

c. An established protocol for responding to clients 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 client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff shall have the capacity to handle the crisis until the client is linked to the outside crisis services.

d. A detailed weekly schedule that is available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule shall specify the program staff, their qualifications, and the scope of their responsibilities.

e. Staffing ratios that are consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352, and, for day treatment intensive, that include at least one staff person whose scope of practice includes psychotherapy.

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

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

The Contractor shall require that if day treatment intensive or day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. The Contractor shall require that there be 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.

f. An expectation that the beneficiary will be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, the Contractor shall ensure that the provider receives Medi-Cal reimbursement for day treatment intensive and day rehabilitation for an individual beneficiary only if the beneficiary is present for at least 50 percent of the scheduled hours of operation for that day.

5. Documentation of day treatment intensive and day rehabilitation that meets the documentation standards described in Exhibit A-Attachment 1-Appendix C. 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 service.

6. At least one contact (face-to-face or by an alternative method (e.g., e-mail, telephone, etc.)) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for day treatment intensive and day rehabilitation.

7. A written program description for day treatment intensive and day rehabilitation. Each provider of these services, including Contractor staff, shall be required to develop and maintain this program description. The written program description shall describe the specific activities of the service and reflect each of the required components of the services described in this section. The Contractor shall review the written program description for compliance with this section for

individual and group providers that begin delivering day treatment intensive or day rehabilitation prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

8. The Contractor shall retain the authority to set additional higher or more specific standards than those set by 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.

9. Authorization Requirements for Related Services

   The Contractor shall require providers to follow the timelines described in this section for MHP payment authorization of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic behavioral services as described in DMH Letter No. 99-03, when these services are provided on the same day as day treatment intensive or day rehabilitation.

X. MHP Payment Authorization Requirements for Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as defined in Title 9, CCR, Section 1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

The Contractor shall require providers to request initial and on-going mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, for TBS as described below. The Contractor's MHP authorization function shall meet the criteria of Exhibit A, Attachment 2, Section B except that the Contractor shall not delegate the MHP payment authorization function to providers. Provider as used in this section includes Contractor staff. In the event that the Contractor is the TBS provider, the Contractor shall assure that the authorization process does not include staff involved in providing TBS. The Contractor shall require providers to submit MHP payment authorization requests prior to the end of the specified days in the current authorization period and shall make timely decisions on MHP payment authorization requests to ensure there is no break in medically necessary services to the beneficiary.

When the Contractor's MHP payment authorization decisions result in denial, modification, deferral, reduction or termination of the services requested by the provider, the Contractor shall provide notices of action (NOAs) in accordance with the requirements of Title 9, CCR, Section 1850.210 and 1850.212 and, when required by Title 9, CCR, Section 1850.215, the continuation of services pending an appeal and a fair hearing decision. When applicable, the NOA shall advise the beneficiary of the right to request continuation of previously authorized services pending the outcome of an appeal and a Medi-Cal fair hearing if the request for the appeal or the hearing is timely.

The MHP payment authorization requirements of this section replace the Contractor's obligations under DMH Letter No. 99-03, page 6, to review the TBS component of a beneficiary's client plan monthly.

1. General Authorization Requirements

   a. The Contractor shall require providers to request MHP payment authorization for TBS in advance of the delivery of the services included in the authorization request. The requirement for approval in advance of the delivery of TBS applies to direct one-to-one TBS and related service activities, but does not include the initial assessment that determines whether or not TBS criteria are met or to the initial development of TBS client plan. The initial assessment may include observation of the beneficiary in the settings in which TBS is expected to be delivered to note baseline behaviors and make a preliminary assessment of likely interventions. The Contractor may reimburse providers for the initial assessment and the initial development of the TBS client plan as a mental health service or as TBS, as determined by the Contractor.

   b. The Contractor shall make a decision on MHP payment authorization requests for TBS in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

   c. Both the initial authorization and subsequent reauthorization decisions shall be made by a licensed practitioner of the healing arts (LPHA) as required by Title 9, CCR, Section 1830.215.

   d. The Contractor shall issue a decision on an MHP payment authorization request for TBS in accordance with the timeliness required by Exhibit A, Attachment 2, Section B and by Title 9, CCR, Section 1810.405(c), except that when the MHP extends the timeline for an expedited authorization request to obtain additional information from the requesting provider, the Contract shall issue a decision on the MHP payment authorization request within three working days of the receipt of the additional information from

the provider or within 14 calendar days of the extension, whichever is earlier.

e. The Contractor retains the authority to set additional standards necessary to manage the delivery of TBS, including but not limited to establishing maximum hours for individual TBS service components (e.g., assessment, client plan development, and collateral services), provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary TBS.

2. Initial Authorization

a. Except as provided in subsection 1,b, the Contractor shall not approve an initial MHP payment authorization request for direct one-to-one TBS that:

   i. Exceeds 30 days if the provider is requesting authorization of direct one-to-one TBS that exceeds 12 hours per day

   ii. Exceeds 60 days if the provider is requesting authorization of direct one-to-one TBS that is less than or equal to 12 hours per day

b. The Contractor shall permit providers to submit initial MHP payment authorization requests that include a TBS client plan that meets only criteria i through v in subsection c. If a provider does submit a TBS client plan that meets only these criteria, the Contractor shall not approve an initial MHP payment authorization request for direct one-to-one TBS that exceeds 30 days.

c. Except as provided in subsection b, the Contractor shall not approve a provider's initial MHP payment authorization request unless the provider has submitted a TBS client plan that meets the criteria in subsections i through viii below

   i. A TBS client plan may be a separate client plan for the delivery of TBS or a component of a more comprehensive client plan. The TBS client plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the beneficiary as identified by the assessment process.

   ii. Clearly identifies specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

iii. Includes a specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.

iv. Includes a specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.

v. Identifies a specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

vi. Includes a transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

vii. As necessary, includes a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

viii. If the beneficiary is between 18 and 21 years of age, includes notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

3. Reauthorization

a. The Contractor shall not approve an MHP payment authorization request for reauthorization of TBS that exceeds 30 days if the provider is requesting authorization of direct one-to-one TBS that exceeds 12 hours per day or exceeds 60 days if the provider is requesting authorization of direct one-to-one TBS that is less than or equal to 12 hours per day.

b. The Contractor shall base decisions on MHP payment authorization requests for reauthorization of TBS on clear documentation of the following and any additional information from the TBS provider required by the Contractor:

   i. The beneficiary's progress towards the specific goals and timeframes of the TBS client plan.

   ii. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness. A strategy to terminate services shall consider the intensity and duration of TBS necessary to stabilize the beneficiary's behavior and reduce the risk of regression.

   iii. If applicable, the beneficiary's lack of progress towards the specific goals and timeframes of the TBS client plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the alternatives will be effective.

   iv. The review and updating of the TBS client plan as necessary to address any significant changes in the beneficiary's environment (e.g., a change in residence).

   v. The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

c. If the initial MHP payment authorization was approved pursuant to subsection 2.b. above, the Contractor shall not approve the MHP payment authorization request for reauthorization of TBS unless the provider has submitted a TBS client plan that meets criteria i through viii in subsection 2.c.

d. When the Contractor approves a fourth MHP payment authorization request for a beneficiary, the Contractor shall provide a summary of the TBS services provided, justification for the additional authorization and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, in writing to the Mental

Health Director for the Contractor and to Medi-Cal Policy and Support, Department of Mental Health, 1600 9th Street, Room 100, Sacramento CA 95814, within five working days of the authorization decision.

Y. Reporting on Procedures for Serving Foster Children Placed Out-of-County

Each year by October 1st, following the October 1, 2005 date that initial reports were submitted to the Department, the Contractor shall provide the Department with an amended report if there are any changes in the Contractor's methods for complying with Welfare and Institutions code, Section 5777.6 (a) and (b). An amended report shall include any changes in the description of the Contractor's procedures or changes in the listing of the mental health plans and/or providers with whom the Contractor has an arrangement, the counties covered by the arrangement and the capacity of each arrangement by service type. Amendments to the report shall also include any changes in description of the Contractor's procedures for providing out-of-plan services in accordance with Title 9, CCR, Section 1830.220, when a beneficiary requires services or is placed in a county not covered by the Contractor's normal procedures.

EXHIBIT A – ATTACHMENT 1 – APPENDIX A

Quality Improvement Program

A. Quality Improvement (QI) Program Description

The Mental Health Plan (MHP) shall have a written Quality Improvement (QI) Program Description, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements shall be included in the QI Program Description:

1. The QI Program Description shall be evaluated annually and updated as necessary

2. The QI Program shall be accountable to the MHP Director

3. A licensed mental health staff person shall have substantial involvement in QI Program implementation

4. The MHP's practitioners, providers, consumers and family members shall actively participate in the planning, design and execution of the QI Program

5. The role, structure, function and frequency of meetings of the QI Committee and other relevant committees shall be specified as follows:

    a. The QI Committee shall oversee and be involved in QI activities, including performance improvement projects.

    b. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; and ensure follow-up of QI processes.

    c. Dated and signed minutes shall reflect all QI Committee decisions and actions.

6. The QI Program shall coordinate with performance monitoring activities throughout the MHP, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances, appeals and fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, and clinical records review

7. Contracts with hospitals and with individual, group and organizational providers shall require: cooperation with the MHP's QI Program, and access

to relevant clinical records to the extent permitted by State and federal laws by the MHP and other relevant parties.

B. Annual QI Work Plan

The QI Program shall have an annual QI Work Plan that includes the following:

1. An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects:

   a. Monitoring of previously identified issues, including tracking of issues over time;

   b. Planning and initiation of activities for sustaining improvement, and

   c. Objectives, scope, and planned activities for the coming year, including QI activities in each of the following six areas. The QI activities in at least two of the six areas and any additional areas required by the Centers for Medicare and Medicaid Services in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a)(2) shall meet the criteria identified in Title 42, CFR, Section 438.240(d) for performance improvement projects. At least one performance improvement project shall focus in a clinical area and one in a non-clinical area.

2. Monitoring the service delivery capacity of the MHP. The MHP shall implement mechanisms to assure the capacity of service delivery within the MHP:

   a. The MHP will describe the current number, types and geographic distribution of mental health services within its delivery system

   b. The MHP shall set goals for the number, type, and geographic distribution of mental health services

3. Monitoring the accessibility of services. In addition to meeting Statewide standards, the MHP will set goals for:

   a. Timelines of routine mental health appointments;

   b. Timeliness of services for urgent conditions;

   c. Access to after-hours care; and

d. Responsiveness of the MHP's 24 hour, toll free telephone number. The MHP shall establish mechanisms to monitor the accessibility of mental health services, services for urgent conditions and the 24 hour, toll-free telephone number.

4. Monitoring beneficiary satisfaction. The MHP shall implement mechanisms to ensure beneficiary or family satisfaction. The MHP shall assess beneficiary or family satisfaction by:

   a. Surveying beneficiary/family satisfaction with the MHP's services at least annually

   b. Evaluating beneficiary grievances, appeals and fair hearings at least annually; and

   c. Evaluating requests to change persons providing services at least annually

   The MHP shall inform providers of the results of beneficiary/family satisfaction activities

5. Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices. The scope and content of the QI Program shall reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries. Annually the MHP shall identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation:

   a. These clinical issues shall include a review of the safety and effectiveness of medication practices. The review shall be under the supervision of a person licensed to prescribe or dispense prescription drugs

   b. In addition to medication practices, other clinical issue(s) shall be identified by the MHP.

6. The MHP shall implement appropriate interventions when individual occurrences of potential poor quality are identified.

7. At a minimum the MHP shall adopt or establish quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

8. Providers, consumers and family members shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system.

9. Monitoring continuity and coordination of care with physical health care providers and other human services agencies. The MHP shall work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries

   a. When appropriate, the MHP shall exchange information in an effective and timely manner with other agencies used by its beneficiaries

   b. The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans

10. Monitoring provider appeals

11. The following process shall be followed for each of the QI work plan activities identified in items 1 through 10 above that are not conducted as performance improvement projects, to ensure the MHP monitoring the implementation of the QI Program. The MHP shall follow the steps below for each of the QI activities:

   a. Collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified

   b. Identify opportunities for improvement and decide which opportunities to pursue

   c. Design and implement interventions to improve its performance

   d. Measure the effectiveness of the interventions

   e. Incorporate successful interventions in the MHP as appropriate

C. MHP Delegation

If the MHP delegates any QI activities there shall be evidence of oversight of the delegated activity by the MHP. A written mutually agreed upon document shall describe:

1. The responsibilities of the MHP and the delegated entity

2. The delegated activities

3. The frequency of reporting to the MHP

4. The process by which the MHP shall evaluate the delegated entity's performance, and

5. The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations

Documentation shall verify that the MHP:

1. Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation

2. Approves the delegated entity's QI Program annually or as defined by contract terms

3. Evaluates annually whether the delegated activities are being conducted in accordance with State and MHP Standards; and

4. Has prioritized and addressed with the delegated entity those opportunities identified for improvement

EXHIBIT A – ATTACHMENT 1 – APPENDIX B

Utilization Management Program

A. Utilization Management (UM) Program Description

The MHP shall have a written description of the Utilization Management (UM) program, in which structures and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements shall be included in the written UM program description:

1. Licensed mental health staff shall have substantial involvement in UM program implementation.

2. A description of the authorization processes used by the MHP:

   a. Authorization decisions shall be made by licensed or "waivered/registered" mental health staff consistent with State regulations.

   b. Relevant clinical information shall be obtained and used for authorization decisions. There shall be a written description of the information that is collected to support authorization decision-making.

   c. The MHP shall use the statewide medical necessity criteria to make authorization decisions.

   d. The MHP shall clearly document and communicate the reasons for each denial.

   e. The MHP shall send written notification to its beneficiaries and providers of the reason for each denial.

3. The MHP shall provide the statewide medical necessity criteria to its providers, consumers, family members and others upon request.

4. Authorization decisions shall be made in accordance with the statewide timeliness standards for authorization of services for urgent conditions established in state regulation.

5. The MHP shall monitor the UM program to ensure it meets the established standards for authorization decision making, and take action to improve performance if it does not meet the established standards.

6. The MHP shall include information about the beneficiary grievance, appeals and fair hearing processes in all denial or modification notifications sent to the beneficiary.

B. UM Program Evaluation

The MHP shall evaluate the UM program as follows:

1. The UM program shall be reviewed annually by the MHP, including a review of the consistency of the authorization process.

2. If an authorization unit is used to authorize services, at least every two years, the MHP shall gather information from beneficiaries and providers regarding their satisfaction with the UM program, and address identified sources of dissatisfaction.

C. MHP Delegation

If the MHP delegates any UM activities, there shall be evidence of oversight of the delegated activity by the MHP.

1. A written mutually agreed upon document shall describe:

   a. The responsibilities of the MHP and the delegated entity

   b. The delegated activities

   c. The frequency of reporting to the MHP

   d. The process by which the MHP evaluates the delegated entity's performance, and

   e. The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations.

2. Documentation shall verify that the MHP:

   a. Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation

   b. Approves the delegated entity's UM program annually

   c. Evaluates annually whether the delegated activities are being conducted in accordance with the State and MHP standards, and

d. Has prioritized and addressed with the delegated entity those opportunities identified for improvement.

EXHIBIT A – ATTACHMENT 1 – APPENDIX C

Documentation Standards for Client Records

The documentation standards are described below under key topics related to client care. All standards shall be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas shall be included as appropriate as a part of a comprehensive client record:

    a. Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.

    b. Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.

    c. Documentation shall describe client strengths in achieving client plan goals.

    d. Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.

    e. Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.

    f. Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.

    g. A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.

    h. For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.

i. Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the counter drugs.

j. A relevant mental status examination shall be documented.

k. A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and /or other assessment data.

2. Timeliness/Frequency Standard for Assessment

The MHP shall establish standards for timeliness and frequency for the above mentioned elements.

B. Client Plans

1. Client Plans shall:

a. Have specific observable and/or specific quantifiable goals

b. Identify the proposed type(s) of intervention

c. Have a proposed duration of intervention(s)

d. 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 MHP providing services

e. When the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,

i. A physician

ii. A licensed/"waivered" psychologist

iii. A licensed/registered/waivered social worker

iv. A licensed/registered/waivered marriage and family therapist or

v. A registered nurse

f. Be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.

i. Client signature on the plan shall be used as the means by which the MHP documents the participation of the client

1. When the client is a long term client as defined by the MHP, and

2. The client is receiving more than one type of service from the MHP

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

iii. The MHP shall give a copy of the client plan to the client on request.

2. Timeliness/Frequency of Client Plan

a. Shall be updated at least annually.

b. The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1.

C. *Progress Notes*

1. Items that shall be contained in the client record related to the client's progress in treatment include:

a. The client record shall provide timely documentation of relevant aspects of client care

b. Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

c. All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable

d. All entries shall include the date services were provided

e. The record shall be legible

f. The client record shall document referrals to community resources and other agencies, when appropriate

g. The client record shall document follow-up care, or as appropriate, a discharge summary

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. Medical Support Services

iii. Crisis Intervention

b. Daily

i. Crisis Residential

ii. Crisis Stabilization (1x/23hr)

iii. Day Treatment Intensive

c. Weekly

i. Day Treatment Intensive: a 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 service.

ii. Day Rehabilitation

iii. Adult Residential

d. Other

i. Psychiatric health facility services: notes on each shift

ii. Targeted Case Management: every service contact, daily, or weekly summary

iii. As determined by the MHP for other services.

EXHIBIT A – ATTACHMENT 1 – APPENDIX D

Provider Certification by the Contractor or the Department

A. Organizational Providers

As a part of the organizational provider certification requirements in Exhibit A, Attachment 1, Section K, and Exhibit E, Section F, Item 5 the Contractor and the Department respectively shall verify, through an on-site review if required by those sections or if determined necessary by the Contractor or the Department respectively, 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 staff.

5. The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, 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 pursuant to Exhibit A, Attachment 1, Section F, and applicable state and federal standards.

7. The organizational provider has staffing adequate to allow the Contractor to claim federal financial participation for the services the organizational provider delivers to beneficiaries, as described in Division 1, Chapter 11, Subchapter 4 of Title 9, CCR, when 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 has as head of service a licensed mental health professional or other appropriate individual as described in Title 9, CCR, Sections 622 through 630.

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 or food stuffs are stored separately from drugs for internal use.

    c. All drugs are stored at proper temperatures, room temperature drugs at 59-86 degrees F and refrigerated drugs at 36-46 degrees F.

    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. IM multi-dose vials are dated and initialed when opened.

    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.

11. 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 Exhibit A, Attachment 1, Section W, paragraph 1.

12. On-site review is not required for hospital outpatient hospital 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.

13. On-site review is not required for primary care and psychological clinics licensed under Division 2, Chapter 1 of the Health and Safety Code. Services

provided by the clinics may be provided either on the premises or off site in accordance with the conditions of their license.

14. When an on site review of an organizational provider would not otherwise be required and the provider provides 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 Exhibit A, Attachment 1, Section W, paragraph 1.

15. 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:

    a. The provider makes major staffing changes.

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

    c. The provider adds day treatment or medication support services when medications shall be administered or dispensed from the provider site.

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

    e. There is a change of ownership or location.

    f. There are complaints regarding the provider.

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

EXHIBIT A – ATTACHMENT 2

Reconciliation with Federal Regulations

The Contractor shall comply with the federal regulations as provided in this attachment.

A. Notification of Beneficiaries

The Contractor shall comply with the informing requirements of Title 42, CFR, Section 438.10 as provided in Exhibit A, Attachment 1, Section V.

B. MHP Payment Authorization

1. The Contractor may place appropriate limits on a service on the basis of the applicable medical necessity criteria in Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210 and utilization control criteria established by the Contractor, as long the criteria are consistent with this section of the contract.

   For the processing of initial and continuing MHP payment authorization requests, the Contractor and any subcontractor to whom the Contractor has delegated MHP payment authorization authority, shall:

   a. Have in place, and follow, written policies and procedures regarding the authorization process that are consistent with Title 9, CCR, Sections 1820.215, 1820.220, 1820.225, 1820.230 and 1830.215, including requirements for involvement of specified licensed mental health professionals in the decision process.

   b. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions consistent with the Utilization Management Program as described in Exhibit A – Attachment 1 - Appendix B.

   c. Consult with the requesting provider when appropriate.

2. The Contractor shall act on MHP authorization requests in accordance with the following timeframes:

   a. For authorization decisions other than expedited decisions described below, provide notice as expeditiously as the beneficiary's mental health condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the beneficiary or the provider, requests extension; or if the Contractor identifies a need for additional information and documents the need and how the extension is in the beneficiary's interest in its

authorization records. If the Contractor extends the timeframe, the Contractor shall provide the beneficiary with written notice of the decision on the date the decision to extend is made. The notice to the beneficiary shall advise the beneficiary of the reason for the decision and the beneficiary's right to file a grievance if the beneficiary disagrees with the decision.

b. In accordance with Title 42, Code of Federal Regulations, Section 438.210 (d) (2), for expedited authorization decisions in cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the Contractor will make an expedited authorization decision and provide notice as expeditiously as the beneficiary's mental health condition requires and no later than three working days after receipt of the request for MHP payment authorization. The Contractor may extend the three-working-day time period by up to 14 calendar days consistent with the beneficiary's request, if the beneficiary requests an extension. If the Contractor identifies a need for additional information and documents the need and how the extension is in the beneficiary's interest in its authorization records, the Contractor may extend the three-working-day time period as follows:

   i. When the MHP payment authorization request is for therapeutic behavioral services (TBS), three working days from the date the additional information is received or 14 calendar days, whichever is less.

   ii. For all other services, up to 14 calendar days.

3. The Contractor shall notify the requesting provider of any decision to deny an MHP payment authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

4. The Contractor shall not structure compensation to any individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

C. *Post-Stabilization Care Services*

1. Notwithstanding Title 9, CCR, Section 1830.220 regarding out-of-plan services, the Contractor is financially responsible for post-stabilization care services obtained within or outside the Contractor's provider network that:

a. Are prior authorized by the Contractor

b. Are not prior authorized by the Contractor, but are delivered by the provider to maintain the beneficiary's stabilized condition within one hour of an MHP payment authorization request for prior authorization of further post-stabilization care services;

c. Are not prior authorized by the Contractor, but are delivered to maintain, improve, or resolve the beneficiary's stabilized condition if:

   i. The Contractor does not respond to an MHP payment authorization request for prior authorization within one hour;

   ii. The Contractor cannot be contacted; or

   iii. The Contractor and the treating physician cannot reach an agreement concerning the beneficiary's care and a Contractor-designated physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor-designated physician and the treating physician may continue with care of the beneficiary until a Contractor-designated physician is reached or one of the criteria in paragraph 2. is met.

2. The Contractor's financial responsibility for post-stabilization care services it has not prior authorized ends when--

   a. A Contractor-designated physician with privileges at the treating hospital assumes responsibility for the beneficiary's care;

   b. A Contractor-designated physician assumes responsibility for the beneficiary's care through transfer;

   c. The Contractor and the treating physician reach an agreement concerning the beneficiary's care; or

   d. The beneficiary is discharged.

D. Emergency Psychiatric Condition Reimbursement

Notwithstanding Title 9, CCR, Sections 1820.225 and 1830.215, the Contractor shall comply with the requirements of Title 42, CFR, Section 438.114 as provided in Exhibit A, Attachment 1, Section C.

EXHIBIT A – ATTACHMENT 3

Additional Requirements Based on Federal Regulations

1. The Contractor shall maintain written policies and procedures respecting advance directives in compliance with the requirements of Title 42, Code of Federal Regulations (CFR), Sections 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.

2. The Contractor shall obtain approval from the Department prior to implementing a Physician Incentive Plan as described at Title 42, CFR, Section 438.6(h). The Department shall approve the Contractor's request only if the proposed Physician Incentive Plan complies with all applicable federal and state regulations.

3. The Contractor shall make a good faith effort to give written notice of termination of a contract with an individual, group or organizational provider, within 15 days after receipt or issuance of the termination notice to the contract provider, to each beneficiary who received his or her mental health services from, or was seen on a regular basis by, the terminated contract provider.

4. The Contractor shall develop, implement and maintain written policies that address the beneficiary's rights and responsibilities as required by Title 42, CFR, Section 438.100 and shall communicate these policies to its beneficiaries and providers.

5. The Contractor shall not prohibit, or otherwise restrict, a licensed, waivered, or registered professional as defined in Title 9, California Code of Regulations (CCR), Sections 1810.223 and 1810.254 acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary for whom the provider is providing mental health services for the following: the beneficiaries health status, medical care, or treatment options, including any alternative treatment that may be self-administered; any information the beneficiary needs in order to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or nontreatment; 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.

6. The Contractor shall obtain prior approval from the Department if the Contractor intends to refuse to provide or arrange and pay for a covered service because the Contractor objects to the service on moral or religious grounds. The Department shall approve the request only if the State is able to provide adequate access to the service or services the Contractor does not intend to provide. If the Department does not approve the request, the Contractor may terminate the contract in accordance with Exhibit E, Section D, Item 2.

7. Pursuant to Title 9, CCR, Section 1810.365, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract except to collect other health insurance coverage, share of cost and co-payments. The Contractor 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 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.

8. The Contractor shall comply with Title 42, CFR, Section 438.236, in which the Contractor is a PIHP (Prepaid Inpatient Health Plan), which provides:

   Sec. 438.236 Practice guidelines.
   (a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.
   (b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:
   (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
   (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.
   (3) Are adopted in consultation with contracting health care professionals.
   (4) Are reviewed and updated periodically as appropriate.
   (c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

9. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and provides information on areas including, but not limited to, utilization, grievances and appeals. The basic elements of the health information system shall at a minimum, collect data on beneficiary and provider characteristics as specified by the Department, and on services furnished to beneficiaries as specified by the Department; ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate. Nothing in this Section requires that all elements of the Contractor's health information system to be collected and analyzed in electronic formats.

10. The Contractor shall certify each claim submitted to the State in accordance with Title 9, CCR, Section 1840.112 at the time the claims are submitted to the State. The Contractor's Chief Financial Officer or equivalent or an individual with authority delegated by the Chief Financial Officer shall sign the certification under penalty of perjury that the state share of payment for services covered by the claim has been provided in order to satisfy the matching requirements for federal financial participation. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification 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 Title 9, CCR, Section 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 State payments to the Contractor, the Contractor shall certify the additional information provided in accordance with Title 42, CFR, Section 438.604.

11. Persons with special health care needs for the purpose of this contract are adults who have a serious mental disorder and children with a serious emotional disturbance. The Contractor shall identify persons with special health care needs through the administration of surveys in accordance with the Department's Performance Outcome System pursuant to the performance contract between the county of the Contractor and the Department required by Welfare and Institutions Code, Section 5650 et seq.

12. 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 contractors' performance to periodic formal review, at a minimum in accordance with the recertification requirements of Exhibit A, Attachment 1, Section K. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor shall take corrective action.

EXHIBIT B

Payment Provisions

The Department agrees to compensate the Contractor in accordance with the allocation amounts specified in Section D below under the conditions described in this Exhibit.

A. Budget Contingency Clauses

Federal Budget: It is mutually agreed that, if the Congress does not appropriate sufficient funds for the program, the State has the option to void the contract or to amend the contract to reflect any reduction of funds. Such amendment shall require Contractor approval.

B. State Budget

It is mutually agreed that if the Budget Act of the current year does not appropriate sufficient funds for the program, this contract will be void and of no further force and effect. In such an event, the State shall have no further liability to pay any funds whatsoever to the Contractor or to furnish any other considerations under this contract, and the Contractor shall not be obligated to perform any provisions of this contract or to provide services intended to be funded pursuant to this contract.

If funding for this contract is reduced or deleted by the Budget Act for the purposes of this program, the State shall have the option to either cancel this contract with no liability occurring to the State, or offer a contract amendment to the Contractor to reflect the reduced amount.

C. Prompt Payment Clause

Payment shall be made in accordance with, and within the time specified in Government Code, Chapter 4.5, commencing with Section 927.

D. Amounts Payable

The total amounts payable for each fiscal year of this contract ending June 30th of each year are as follows:

Fiscal Year	Interim Allocated Amount	Final Allocated Amount
FY 2006-07	«AllocatedAmount»	«FinalAllocated»
FY 2007-08	«FinalAllocated»	
FY 2008-09		

These interim and final allocated amounts will be amended annually to reflect the appropriate dollar amount per Fiscal Year based on the current State Budget.

Any requirement of performance by the Department and the Contractor for this period shall be dependent upon the availability of future appropriations by the Legislature for the purpose of this contract. The services shall be provided at the times required by this contract.

E. Payment to the Contractor

The Contractor shall receive a single payment per fiscal year for the full amount payable per fiscal year under Section D for each fiscal year within 60 calendar days of the determination of the amount by the Department in accordance with Title 9, California Code of Regulations (CCR), Section 1810.330, or the enactment of the State Budget for the fiscal year, whichever is later.

F. Payment in Full

The amount payable under Section D, referred to hereafter as the allocation amount, constitutes payment in full by the Department of the State matching funds on behalf of beneficiaries for all covered services and for all utilization review and administrative costs incurred by the Contractor in providing or arranging for such services, except for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits.

State matching funds, in addition to the amount payable under Section D, for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits shall be paid in accordance with the annual All County Mental Health Directors Letter entitled "Distribution for Early and Periodic Screening, Diagnosis, and Treatment State Funding" for each fiscal year.

G. Determination of Allocation Amount

The allocation amount shall be set annually on a formula basis as determined by the Department in consultation with a statewide organization representing counties pursuant to Section 5778, Welfare and Institutions (W&I) Code.

H. Renegotiation or Adjustment of Allocation Amount

1. To the extent permitted by federal law, either the Department or the Contractor may request that contract negotiations of the allocation amount be reopened during the course of a contract due to substantial changes in the cost of covered services or related obligations that result from new legislative requirements affecting the scope of services or eligible population, or other unanticipated event. Any change in the allocation amount under this section

is subject to the availability of funds. Any change in allocation amount shall be retroactive to the effective date of the change authorizing the amendment.

2. The allocation amount may be changed pursuant to a change in the obligation of the Contractor as a result of a change in the obligations of a Medi-Cal managed care plan for services that would be covered by the Contractor if they were not covered by the Medi-Cal managed care plan, pursuant to Title 9, CCR, Section 1810.345 and Section 1810.355(a)(5). Any change in allocation amount shall be retroactive to the effective date of the change authorizing the amendment.

I. Disallowances and Offsets

In the event of disallowances or offsets as a result of federal audit exceptions, the provisions of Section 5778(h), W&I Code shall apply.

The Department shall offset the state matching funds for payments made by the Medi-Cal fiscal intermediary pursuant to Section 5778(g), W&I Code, against any funds held by the Department on behalf of the Contractor.

J. Federal Financial Participation

Nothing in this contract shall limit the Contractor from being reimbursed appropriate federal financial participation for any covered services or utilization review and administrative costs even if the total expenditure for services exceeds the contract amount.

K. Cost Reporting

The Contractor shall submit a fiscal year-end cost report, due no later than December 31st following the close of each fiscal year in accordance with W&I Code §§ 5651(a) (4), 5664(a) and (b), 5705 (b)(3), 5718(c) and guidelines established by the Department. Data submitted shall be full and complete. The Contractor shall also submit a reconciled cost report for each fiscal year certified by the mental health director and the county's auditor-controller as being true and correct, no later than April 1st of the following fiscal year.

If the Contractor does not submit the cost reports by the reporting deadlines the Department may withhold payments of the funds described in Section D to the Contractor.

EXHIBIT D

Special Provisions

A. Fulfillment of Obligation

No covenant, condition, duty, obligation, or undertaking continued or made a part of this contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party shall have the right to invoke any remedy available under this contract, or under law, notwithstanding such forbearance or indulgence.

B. Amendment of Contract

Should either party during the life of this contract desire a change in this contract, such change will be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within 10 days and shall have 60 days after receipt of such proposal to review and consider the proposal, to consult and negotiate with the proposing party, and to accept or reject the proposal. Acceptance or rejection may be made orally within said 60-day period, and confirmed in writing within five days thereafter. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any such proposal shall set forth a detailed explanation of the reason and basis for the proposed change, a complete statement of cost and benefits of the proposed change and the text of the desired amendment to this contract that would provide for the change. If the proposal is accepted, this contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by the Department of General Services, if necessary.

C. Contract Disputes

Should a dispute arise between the Contractor and the Department relating to performance under this contract other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, Title 9, California Code of Regulations (CCR), the Contractor shall, prior to exercising any other remedy which may be available, provide the Department with written notice of the particulars of the dispute within 30 calendar days of the dispute. The Department shall meet with the Contractor, review the factors in the dispute, and recommend a means of resolving the dispute before a written response is given to the Contractor. The Department shall provide a written response to the Contractor within 30 days of receipt of the Contractor's written notice.

D. Inspection Rights

The Contractor shall allow the Department, DHS, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the Contractor and subcontractors, pertaining to such services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including working papers, reports, financial records and books of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries. Upon request, at any time during the period of this contract, the Contractor shall furnish any such record, or copy thereof, to the Department, DHS, or HHS. Authorized agencies shall maintain the confidentiality of such books and records in accordance with applicable laws and regulations.

E. Notices

All notices to be given under this contract shall be in writing and shall be deemed to have been given when mailed, to the Department or the Contractor at the following addresses, unless the contract explicitly requires notice to another individual or organizational unit:

State Dept. of Mental Health
County Operations Section
Systems of Care Division
1600 9th Street, Room 100
Sacramento, CA 95814

F. Confidentiality

1. The parties to this agreement shall comply with applicable laws and regulations, including but not limited to Section 5328 et seq. and Section 14100.2 of the Welfare and Institutions (W&I) Code and Title 42, Code of Federal Regulations (CFR), Section 431.300 et seq. and Exhibit E, Section E the HIPAA Business Associate Agreement regarding the confidentiality of beneficiary information.

2. The Contractor shall protect from unauthorized disclosure, names and other identifying information concerning beneficiaries receiving services pursuant to this contract except for statistical information. The Contractor shall not use identifying information for any purpose other than carrying out the Contractor's obligations under this contract.

3. The Contractor shall not disclose, except as otherwise specifically permitted by state and federal laws and regulation or this contract or authorized by the beneficiary, any such identifying information to anyone other than the State without prior written authorization from the State in accordance with state and federal laws.

4. For purposes of the above paragraphs, identifying information will include, but not be limited to: name, identifying number, symbol, or other identifying particular assigned to the individual.

G. Nondiscrimination

1. Consistent with the requirements of applicable federal or state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical handicap.

2. The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977.

3. The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.

4. Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to Title 9, CCR, Section 1820.205, Section 1830.205 or Section 1830.210, prior to providing covered services to a beneficiary.

H. Patients' Rights

The parties to this contract shall comply with applicable laws, regulations and State policies relating to patients' rights.

I. Relationship of the Parties

The Department and the Contractor are, and shall at all times be deemed to be, independent agencies. Each party to this agreement shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this agreement. Nothing herein contained will be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their

agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department, its agents and employees, shall not be entitled to any rights or privileges of Contractor employees and shall not be considered in any manner to be Contractor employees. The Contractor, its agents and employees, shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

J. Waiver of Default

Waiver of any default will not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this agreement will not be deemed to be a waiver of any other or subsequent breach, and will not be construed to be a modification of the terms of this contract.

K. Additional Contract Provisions

1. The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act (18 U.S.C. 874 and 40 U.S.C. 276c), which requires that all contracts and subcontracts in excess of $2000 for construction or repair awarded by the Contractor and its subcontractors shall include a provision for compliance with the Copeland Anti-Kickback Act (18 U.S.C. 874), as supplemented by Department of Labor regulations (Title 29, CFR, Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in part by Loans or Grants from the United States").

2. The Contractor shall comply with the provisions of Davis-Bacon Act, as amended (40 U.S.C. 276a to a-7), which requires that, when required by Federal Medicaid program legislation, all construction contracts awarded by the Contractor and its subcontractors of more than $2,000 shall include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (Title 29, CFR, Part 5, "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction").

3. The Contractor shall comply with the provisions of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327-333), as applicable, which requires that all subcontracts awarded by the Contractor in excess of $2,000 for construction and in excess of $2,500 for other subcontracts that involve the employment of mechanics or laborers shall include a provision for compliance with sections 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327-333), as supplemented by Department of Labor regulations (Title 29, CFR, Part 5).

4. The Contractor shall comply with the provisions of Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et

seq.), as amended, which provide that contracts and subcontracts of amounts in excess of $100,000 shall contain a provision that requires the Contractor or subcontractor to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act and the Federal Water Pollution Control Act. Violations shall be reported to the Centers for Medicare and Medicaid Services.

5. The Contractor shall comply with the provisions of Title 42, CFR, Section 438.610 and Executive Orders 12549 and 12689, "Debarment and Suspension," which excludes parties listed on the General Services Administration's list of parties excluded from federal procurement or non-procurement programs from having a relationship with the Contractor.

6. The Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Social Security Act. Federal financial participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or the State Children's Insurance Program, except for emergency services.

EXHIBIT E

Additional Provisions

A. General Authority

This contract is entered into in accordance with the provisions of Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions (W&I) Code.

Part 2.5 (commencing with Section 5775) of Division 5 of the W&I Code directs the State Department of Mental Health to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state; and «MHP_Name» desires to operate the Mental Health Plan for «County» County.

B. Definitions

Unless otherwise expressly provided or the context otherwise requires, the following definitions of terms shall govern the construction of this contract:

1. "Beneficiary" means any Medi-Cal beneficiary whose county of responsibility on the Medi-Cal Eligibility Data System (MEDS) or as determined pursuant to Title 9, California Code of Regulations (CCR), Section 1850.405, corresponds with the county covered by this contract.

2. "Contractor" means «MHP_Name».

3. "Covered Services" means specialty mental health services as defined in Title 9, CCR, Section 1810.247, to the extent described in Title 9, CCR, Section 1810.345, except that psychiatric nursing facility services are not included.

4. "Department" means the State Department of Mental Health.

5. "DHS" means the State Department of Health Services.

6. "Director" means the Director of the State Department of Mental Health.

7. "HHS" means the United States Department of Health and Human Services.

8. "Emergency Psychiatric Condition" means that a beneficiary has a condition that meets admission reimbursement criteria for medical necessity according to Title 9, CCR, Section 1820.205, and due to a mental disorder, is:

   a. A danger to self or others, or

b. Immediately unable to provide for or utilize food, shelter or clothing.

9. "Facility" means any premises:

a. Owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this contract, or

b. Maintained by a provider to provide covered services on behalf of «MHP_Name».

10. "Individual provider" means a provider as defined in Title 9, CCR, Section 1810.222.

11. "Group provider" means a provider as defined in Title 9, CCR, Section 1810.218.2.

12. "Medi-Cal managed care plan" means an entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3 of the W&I Code.

13. "Organizational provider" means a provider as defined in Title 9, CCR, Section 1810.231.

14. "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, or, under the circumstances described in Exhibit A, Attachment 2, Section C, to improve or resolve the enrollee's condition. Post-stabilization care services include psychiatric consults in an emergency room following the initial evaluation to be post-stabilization services, if the consult does not result in a determination that the beneficiary must be admitted for emergency psychiatric inpatient hospital services. Post-stabilization services also include medically necessary acute psychiatric inpatient hospital services after the emergency psychiatric condition has been resolved.

15. "Psychiatric nursing facility services" means services as defined in Title 9, CCR, Section 1810.239.

16. "Public school site" means a location on the grounds of a public school at which a provider delivers specialty mental health services to beneficiaries.

17. "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to

beneficiaries less 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.

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

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

    b. 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.

19. "Urgent condition" means a situation experienced by a beneficiary that without timely intervention is likely to result in an immediate emergency psychiatric condition.

C. *General Provisions*

1. Governing Authorities

   This contract shall be governed by and construed in accordance with:

   a. Part 2.5 (commencing with Section 5775), Chapter 4, Division 5, W&I Code;

   b. Article 5 (Sections 14680- 14685), Chapter 8.8, Division 9, W&I Code;

   c. Title 9, CCR, Division 1, Chapter 11 (commencing with Section 1810.100);

   d. Title 42, Code of Federal Regulations (CFR);

   e. Title 45, CFR, Parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable;

   f. Title 42, United States Code;

   g. Title VI of the Civil Rights Act of 1964;

   h. Title IX of the Education Amendments of 1972;

   i. Age Discrimination Act of 1975;

j. Rehabilitation Act of 1973;

k. Titles II and III of the Americans with Disabilities Act;

l. All other applicable laws and regulations; and

m. The terms and conditions of any Interagency Agreement between the Department of Mental Health and the State Department of Health Services related to the provision of mental health services to beneficiaries by the Contractor.

2. Any provision of this contract that is subsequently determined to be in conflict with the above laws, regulations, and agreements is hereby amended to conform to the provisions of those laws, regulations and agreements. Such amendment of the contract shall be effective on the effective date of the statutes, regulations or agreements necessitating it, and shall be binding on the parties hereto even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. Such amendment shall constitute grounds for termination of this contract, in accordance with the provisions of and Title 9, CCR, Section 1810.323, if the Contractor determines it is unable or unwilling to comply with the provisions of such amendment. If the Contractor gives notice of termination to the Department, the parties shall not be bound by the terms of such amendment, commencing from the time notice of termination is received by the Department until the effective date of termination.

3. Uniform resource locators (URLs) for state and federal regulations that are cited by section number in this contract are included as Exhibit E. Attachment 1.

D. Term and Termination

1. Contract Renewal

   This contract may be renewed unless good cause is shown for non-renewal pursuant to Title 9, CCR, Section 1810.321. This contract shall be renewed every three years.

2. Contract Termination

   The Department or the Contractor may terminate this contract in accordance with Title 9, CCR, Section 1810.323.

3. Mandatory Termination

The Department shall immediately terminate this contract in the event that the Director determines that there is an immediate threat to the health and safety of beneficiaries. The department shall terminate this contract in the event that the Secretary, HHS, determines that the contract does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Terminations under this section shall be in accordance with Title 9, CCR, Section 1810.323.

4. Termination of Obligations

All obligations to provide covered services under this contract shall automatically terminate on the effective date of any termination of this contract. The Contractor shall be responsible for providing covered services to beneficiaries until the termination or expiration of the contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to beneficiaries prior to such expiration or termination.

E. HIPAA Provisions

1. The parties to this agreement shall comply with applicable laws and regulations, including but not limited to Sections 14100.2 and 5328 et seq. of the Welfare and Institutions Code, Section 431.300 et seq. of Title 42, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act (HIPAA), including but not limited to Section 1320 D et seq, of Title 42, United States Code and it's implementing regulations (including but not limited to Title 45, CFR, Parts 142, 160, 162 and 164) regarding the confidentiality and security of patient information.

2. The Contractor shall protect, from unauthorized disclosure, names and other identifying information concerning persons receiving services pursuant to this Contract, except for statistical information. This pertains to any and all persons receiving services pursuant to a DMH-funded program. The Contractor shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Contract.

3. The Contractor shall not disclose, except as otherwise specifically permitted by this Contract, authorized by law or authorized by the client/patient, any such identifying information to anyone other than the State without prior written authorization from the State in accordance with State and Federal Laws.

4. For purposes of the above paragraphs, identifying information shall include, but not be limited to, name, identifying number, symbol, or other identifying

particular assigned to the individual, such as finger or voice print, or a photograph.

5. Notification of Electronic Breach or Improper Disclosure: During the term of this Agreement, Contractor shall notify DMH, immediately upon discovery of any breach of Medi-Cal Protected Health Information (PHI) and/or data, where the information and/or data is reasonably believed to have been acquired by an unauthorized person. Immediate notification shall be made to the DMH Information Security Officer, within two business days of discovery, at (916) 651-6776. Contractor shall take prompt corrective action to cure any deficiencies and any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations. Contractor shall investigate such breach and provide a written report of the investigation to the DMH Information Security Officer, postmarked within thirty (30) working days of the discovery of the breach to the address below:

Information Security Officer
Office of HIPAA Compliance
California Department of Mental Health
1600 9th Street, Room 150
Sacramento, CA 95814

6. *Safeguards.* To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the protected health information, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DMH; and to prevent use or disclosure of PHI other than as provided for by this Agreement. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. Contractor will provide DMH with information concerning such safeguards as DMH may reasonably request from time to time.

   Contractor will implement strong access controls and other security safeguards and precautions as noted in the following to restrict logical and physical access to confidential, personal (e.g., PHI) or sensitive data to authorized users only.

   Contractor will enforce the following administrative and technical password controls on all systems used to process or store confidential, personal, or sensitive data:

   a. Passwords must not be:

i. shared or written down where they are accessible or recognizable by anyone else, such as taped to computer screens, stored under keyboards, or visible in a work area

ii. a dictionary word

iii. stored in clear text

b. Passwords must be:

i. 8 characters or more in length

ii. changed every 90 days

iii. changed immediately if revealed or compromised

iv. composed of characters from at least three of the following four groups from the standard keyboard:

(1) Upper case letters (A-Z);

(2) Lower case letters (a-z);

(3) Arabic numerals (0 through 9); and

(4) Non-alphanumeric characters (punctuation symbols)

Contractor will implement the following security controls on each workstation or portable computing device (e.g., laptop computer) containing confidential, personal, or sensitive data:

a. network-based firewall and/or personal firewall
b. continuously updated anti-virus software
c. patch management process including installation of all operating system/software vendor security patches

Contractor will utilize a commercial encryption solution that has received FIPS 140-2 validation to encrypt all confidential, personal, or sensitive data stored on portable electronic media (including, but not limited to, CDs and thumb drives) and on portable computing devices (including, but not limited to, laptop and notebook computers).

Contractor will not transmit confidential, personal, or sensitive data via e-mail or other internet transport protocol unless the data is encrypted by a solution that

has been validated by the National Institute of Standards and Technology (NIST) as conforming to the Advanced Encryption Standard (AES) Algorithm.

7. *Mitigation of Harmful Effects.* To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor or its subcontractors in violation of the requirements of these Provisions.

8. *Contractor's Contractors.* To ensure that any contractors, including subcontractors, to whom Contractor provides PHI received from or created or received by Contractor on behalf of DMH, agree to the same restrictions and conditions that apply to Contractor with respect to such PHI; and to incorporate, when applicable, the relevant provisions of these Provisions into each subcontract or sub award to such agents or subcontractors.

9. *Employee Training and Discipline.* To train and use reasonable measures to ensure compliance with the requirements of these Provisions by employees who assist in the performance of functions or activities on behalf of DMH under this Agreement and use or disclose PHI; and discipline such employees who intentionally violate any provisions of these Provisions, including termination of employment.

10. *Termination for Cause.* Upon DMH's knowledge of a material breach of these Provisions by Contractor, DMH shall either:

    a. Provide an opportunity for Contractor to cure the breach or end the violation and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by DMH; or

    b. Immediately terminate this Agreement if Contractor has breached a material term of these Provisions and cure is not possible.

    c. If neither cure nor termination is feasible, the DMH Privacy Officer shall report the violation to the Secretary of the U.S. Department of Health and Human Services.

11. *Judicial or Administrative Proceedings.* DMH may terminate this Agreement, effective immediately, if (i) Contractor is found guilty in a criminal proceeding for a violation of the HIPAA Privacy or Security Rule or (ii) a finding or stipulation that the Contractor has violated a privacy or security standard or requirement of HIPAA, or (iii) other security or privacy laws is made in an administrative or civil proceeding in which the Contractor is a party.

12. *Effect of Termination.* Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all PHI received from DMH (or created or received by Contractor on behalf of DMH) that Contractor still maintains in any form, and shall retain no copies of such PHI or, if return or destruction is not feasible, it shall continue to extend the protections of these Provisions to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Contractor.

13. *Disclaimer.* DMH makes no warranty or representation that compliance by Contractor with these Provisions, HIPAA or the HIPAA regulations will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized use or disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of PHI.

14. *Amendment.* The parties acknowledge that Federal and State laws relating to electronic data security and privacy are rapidly evolving and that amendment of these Provisions may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DMH's request, Contractor agrees to promptly enter into negotiations with DMH concerning an amendment to these Provisions embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA regulations or other applicable laws. DMH may terminate this Agreement upon thirty (30) days written notice in the event (i) Contractor does not promptly enter into negotiations to amend these Provisions when requested by DMH pursuant to this Section or (ii) Contractor does not enter into an amendment providing assurances regarding the safeguarding of PHI that DMH in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

15. *No Third-Party Beneficiaries.* Nothing express or implied in the terms and conditions of these Provisions is intended to confer, nor shall anything herein confer, upon any person other than DMH or Contractor and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

16. *Interpretation.* The terms and conditions in these Provisions shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA regulations and applicable State laws. The parties agree that any

ambiguity in the terms and conditions of these Provisions shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA regulations.

17. *Regulatory References.* A reference in the terms and conditions of these Provisions to a section in the HIPAA regulations means the section as in effect or as amended.

18. *Survival.* The respective rights and obligations of Contractor under Section 6.C of these Provisions shall survive the termination or expiration of this Agreement.

19. *No Waiver of Obligations.* No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

F. Duties of the State

In discharging its obligations under this contract, the State shall perform the following duties:

1. Payment for Services

   Pay the appropriate payments set forth in Exhibit B.

2. Reviews

   Conduct reviews of access and quality of care at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, under Title 9, CCR, Sections 1810.380 and 1810.385. Arrange for an annual external quality review of the Contractor as required by Title 42, CFR, Section 438,204(d).

3. Monitoring for Compliance

   Monitor the operation of the Contractor for compliance with the provisions of this contract, and applicable federal and state law and regulations. Such monitoring activities will include, but not be limited to, inspection and auditing of Contractor facilities, management systems and procedures, and books and records as the Department deems appropriate, at any time during the Contractor's or facility's normal business hours. When monitoring activities identify areas of non-compliance, issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, under Title 9, CCR, Sections 1810.380 and 1810.385.

4. Approval Process

a. In the event that the Contractor requests changes to its Implementation Plan, the Department shall provide a Notice of Approval or Notice of Disapproval including the reasons for the disapproval, to the Contractor within 30 calendar days after the receipt of the request from the Contractor. The Contractor may implement the proposed changes 30 calendar days from submission to the Department, if the Department fails to provide a Notice of Approval or Disapproval.

b. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Exhibit A, Attachment 1, Section J. The Department shall provide a Notice of Approval or a Notice of Disapproval including the reasons for the disapproval, to the Contractor within 60 calendar days after the receipt of the plan from the Contractor. The Contractor may implement the plan 60 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

c. The Department shall act promptly to review requests from the Contractor for approval of subcontracts with providers that meet the conditions described in Title 9, CCR, Section 1810.438. The Department shall act to approve or disapprove the reimbursement and related claiming and cost reporting issues included in the subcontract within 60 days of receipt of a request from the Contractor. If the Department disapproves the request, the Department shall provide the Contractor with the reasons for disapproval.

5. Certification of Organizational Provider Sites Owned or Operated by the Contractor

The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Exhibit A, Attachment 1, Appendix D. This certification shall be prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every three years after that date, unless the Department determines an earlier date is necessary. The on-site review required by Title 9, CCR, Section 1810.435(e), shall be made of any site owned, leased, or operated by the Contractor and used for to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

The Department may allow the Contractor to begin delivering covered services to beneficiaries at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is latest of the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained.

The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department 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.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of federal financial participation by the Contractor and the Department's tracking of that information.

6. Distribution of Informing Materials

Provide annual notice to all beneficiaries in accordance with Title 42, CFR, Section 438.10(f)(2), and Title 9, CCR, Section 1810.360(c).

7. Sanctions

Apply oversight and sanctions in accordance with Title 9, CCR, Sections 1810.380 and 1810.385, to the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations.

8. Notification

Notify beneficiaries of their Medi-Cal specialty mental health benefits and options available upon termination or expiration of this contract.

9. Performance Measurement

Measure the Contractor's performance based on Medi-Cal approved claims and other data available to the Department using standard measures established by the Department in consultation with the State Quality Improvement Council.

10. Data Certification

Require that the Contractor certify data provided by the Contractor that will be used by the State to determine payment rates to the Contractor in accordance with Title 42, CFR, Section 438.604 and 438.606.

G. *Subcontracts*

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

2. All subcontracts must be in writing.

3. All inpatient subcontracts must require that subcontractors maintain necessary licensing and certification.

4. Each subcontract must contain:

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

   b. Specification of the services to be provided.

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

   d. 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.

   e. The nondiscrimination and compliance provisions of this contract as described in Exhibit D, Section G.

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

   g. 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, DHS, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives, 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 keeping, for a term of at least five years from the close of the Department's fiscal year in which the subcontract was in effect.

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

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

j. If applicable based on the services provided under the subcontract, the subcontractor's agreement to comply with the Contractor's policies and procedures on advance directives pursuant to Exhibit A, Attachment 3, Item 1, and the Contractor's obligations for Physician Incentive Plans pursuant to Exhibit A, Attachment 3, Item 2.

EXHIBIT E – ATTACHMENT 1

State and Federal Regulations Governing this Contract

Contractor agrees to comply with the statutes and regulations incorporated by reference below in its provision of services under the Mental Health Plan. Any changes to these statutes and regulations will be updated at the sites provided below. Contractor agrees to comply with any changes to these statutes and regulations that may occur during the contract period.

The State Statute and State and Federal regulations referenced in this contract can be accessed at the following URLs:

State Statute under Division 5, Welfare and Institutions (W&I) Code

http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic&code

Title 42, Code of Federal Regulations (CFR). Part 438, Managed Care

http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr438_05.html

Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services

http://www.dmh.ca.gov/Admin/regulations/docs/FinalRegsText_CLEAR_06Jun27.pdf