Exhibit A
SCOPE OF WORK

1. Service Overview

The Contractor agrees to provide to the California Department of Health Care Services (hereinafter referred to as DHCS, The Department, or the state) the services described herein.

The Contractor will provide or arrange for the provision of specialty mental health services to eligible Medi-Cal members of County Name within the scope of services defined in this contract.

2. Service Location

The services shall be performed at all contracting and participating facilities of the Contractor.

3. Service Hours

The services shall be provided on a 24-hour, seven (7) days a week basis.

4. Project Representatives

A. The project representatives during the term of this contract will be:

Department of Health Care Services	**Contractor Name**
Donnie Boyett Telephone: 209-261-0085 Email: Donnie.Boyett@DHCS.ca.gov	Contractor contact name Telephone: XXX-XXX-XXXX Fax: XXX-XXX-XXXX Email: XXXX

B. Direct all inquiries to:

Department of Health Care Services	**Contractor Name**
Medi-Cal Behavioral Health Division/Program Policy Section Attention: Dee Taylor 1501 Capitol Avenue, MS 2702 Sacramento, CA, 95814 Telephone: (916) 713-8509 Email: Dee.Taylor@dhcs.ca.gov	Attention: Contact name Address: XXXX Telephone: XXX-XXX-XXXX Fax: XXX-XXX-XXXX Email: XXXX

C. 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.

Exhibit A
SCOPE OF WORK

5. General Authority

This Contract is entered into in accordance with the Welfare and Institutions (W&I Code § 14680 through §14727. W&I Code § 14712 directs the California Department of Health Care Services (Department) to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state through contracts with mental health plans. The Department and [Contractor Name] agrees to operate the Mental Health Plan (MHP) for [Contractor county] County. No provision of this contract is intended to obviate or waive any requirements of applicable law or regulation, in particular, the provisions noted above. In the event a provision of this contract is open to varying interpretations, the contract provision shall be interpreted in a manner that is consistent with applicable law and regulation.

6. Electronic and IT Accessibility Requirements Under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990

The Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794 (d)), and regulations implementing that Act as set forth in Part 1194 of Title 36 of the Code of Federal Regulations (C.F.R.), and the portions of the Americans with Disabilities Act of 1990 related to electronic and IT accessibility requirements and implementing regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

7. Services to be Performed

See Exhibit A, Attachments 1 through 15 for a detailed description of the services to be performed.

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

1. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan as approved by the Department, including the administration of member problem resolution processes. (California Code of Regulations (Cal. Code Regs.) Title (tit.) 9, §§ 1810.310, 1850.205-1850.208.) The Contractor shall obtain written approval by the Department prior to making any changes to the Implementation Plan as approved by the Department. The Contractor may implement the changes if the Department does not respond in writing within thirty calendar (30) days. (Cal. Code Regs. tit. 9, § 1810.310(c)(5).)

2. Prohibited Affiliations

A. The Contractor shall not knowingly have any prohibited type of relationship with the following:

1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. (42 C.F.R. § 438.610(a)(1).)

2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in this section. (42 C.F.R. § 438.610(a)(2).)

B. The Contractor shall not have a prohibited type of relationship by employing or contracting with providers or other individuals and entities excluded from participation in federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128 (42 U.S.C. § 1320a-7), 1128A (42 U.S.C. § 1320a-7a), 1156 (42 U.S.C. § 1320c-5), or 1842(j)(2) (42 U.S.C. § 1395u(j)(2)) of the Social Security Act. (42 C.F.R. §§ 438.214(d)(1), 438.610(b).)

C. The Contractor shall not have types of relationships prohibited by this section with an excluded, debarred, or suspended individual, provider, or entity as follows:

1) A director, officer, agent, managing employee, or partner of the Contractor. (42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1).)

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

2) A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230. (42 C.F.R. § 438.610(c)(2).)

3) A person with beneficial ownership of 5 percent or more of the Contractor's equity. (42 C.F.R. § 438.610(c)(3).)

4) An individual convicted of crimes described in section 1128(b)(8)(B) of the Act. (42 C.F.R. § 438.808(b)(2).)

5) A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract. (42 C.F.R. § 438.610(c)(4).)

6) The Contractor shall not employ or contract with, directly or indirectly, such individuals or entities for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services (or the establishment of policies or provision of operational support for such services). (42 C.F.R. § 438.808(b)(3).)

D. The Contractor shall provide to the Department written disclosure of any prohibited affiliation identified by the Contractor or its subcontractors. (42 C.F.R. § 438.608(c)(1).)

3. Delegation

Unless specifically prohibited by this contract or by federal or state law, the Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if the Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Mental Health Plan may have with any subcontractor. (42 C.F.R. § 438.230(b)(1).)

4. Subcontracts

A. This provision is a supplement to provision number five (Subcontract Requirements) in Exhibit D(F) which is attached hereto as part of this contract. As allowed by provision five in Exhibit D(F), the Department

hereby, and until further notice, waives its right to prior approval of subcontracts and approval of existing subcontracts.

B. No subcontract terminates the legal responsibility of the Contractor to the Department to assure that all activities under this contract are carried out. (42 C.F.R. § 438.230(b).)

C. All subcontracts shall be in writing.

D. All subcontracts for inpatient and residential services shall require that subcontractors maintain necessary licensing and certification or mental health program approval.

E. Each subcontract shall contain:

1) The delegated activities and obligations, including services provided, and related reporting responsibilities. (42 C.F.R. § 438.230(c)(1)(i).)

2) The subcontractor's agreement to perform the delegated activities and reporting responsibilities in compliance with the Contractor's obligations in this Contract. (42 C.F.R. § 438.230(c)(1)(ii).)

3) Subcontractor's agreement to submit reports as required by the Contractor and/or the Department.

4) The method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

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

6) Requirement that the subcontractor comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. (42 C.F.R. § 438.230(c)(2).)

7) Terms of the subcontract including the beginning and ending dates, as well as methods for amendment and, if applicable, extension of the subcontract.

8) Provisions for full and partial revocation of the subcontract, delegated activities or obligations, or application of other remedies

permitted by state or federal law when the Department or the Contractor determine that the subcontractor has not performed satisfactorily. (42 C.F.R. § 438.230(c)(1)(iii).)

9) The nondiscrimination and compliance provisions of this contract.

10) A requirement that the subcontractor make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable, available at any time for inspection, examination or copying by the Department, CMS, HHS Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (42 C.F.R. §438.230(c)(3)(i)-(ii).) This audit right will exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. (42 C.F.R. § 438.230(c)(3)(iii).) The Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the subcontractor's place of business, premises or physical facilities. (42 C.F.R. § 438.230(c)(3)(iv).)

11) Subcontractor shall maintain books and records of its work pursuant to its subcontract, in accordance with the general standards applicable to such book or record keeping, for a term of at least ten years from the close of the state fiscal year in which the subcontract was in effect. Subcontractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from the Contractor.

12) A requirement that the Contractor monitor the subcontractor's compliance with the provisions of the subcontract and this contract and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified.

13) Subcontractor's agreement to hold harmless both the State and members in the event the Contractor cannot or does not pay for

services performed by the subcontractor pursuant to the subcontract.

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

5. Accreditation Status

A. The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity. (42 C.F.R. § 438.332(a).)

B. If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall authorize the private independent accrediting entity to provide the Department a copy of its most recent accreditation review, including:

1) Its accreditation status, survey type, and level (as applicable);

2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

3) The expiration date of the accreditation. (42 C.F.R. § 438.332(b).)

6. Conflict of Interest

A. The Contractor shall comply with the conflict-of-interest safeguards described in 42 Code of Federal Regulations section 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Social Security Act. (42 C.F.R. § 438.3(f)(2).)

B. The Contractor’s officers and employees shall not have a financial interest in this Contract, or a subcontract of this Contract made by them in their official capacity, or by any body or board of which they are members unless the interest is remote. (Gov. Code §§ 1090, 1091; 42 C.F.R. § 438.3(f)(2).)

C. No public officials at any level of local government shall make, participate in making, or attempt to use their official positions to influence a decision made within the scope of this Contract in which they know or have reason

to know that they have a financial interest. (Gov. Code §§ 87100, 87103; Cal. Code Regs., tit. 2, § 18704; 42 C.F.R. § 438.3(f)(2).)

1) If a public official determines not to act on a matter due to a conflict of interest within the scope of this Contract, the Contractor shall notify the Department by oral or written disclosure. (Cal. Code Regs., tit. 2, § 18707; 42 C.F.R. § 438.3(f)(2).)

2) Public officials, as defined in Government Code section 87200, shall follow the applicable requirements for disclosure of a conflict of interest or potential conflict of interest, once it is identified, and recuse themselves from discussing or otherwise acting upon the matter. (Gov. Code § 87105, Cal. Code Regs., tit. 2, § 18707(a); 42 C.F.R. § 438.3(f)(2).)

D. The Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. (Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2).)

1) The Contractor shall submit documentation to the Department of employees (current and former State employees) who may present a conflict of interest.

Exhibit A – Attachment 2
SCOPE OF SERVICES

1. Criteria for Members to Access Specialty Mental Health Services (SMHS)

Effective January 1, 2022, the Contractor shall implement the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services) established below, update the Contractor's policies and procedures as needed to ensure compliance with this policy effective January 1, 2022, and communicate these updates to providers as necessary.

In addition, the Contractor shall update member handbooks, manuals, and related materials to ensure the criteria for SMHS for individuals under 21 years of age and for adults is accurately reflected in all materials, including materials reflecting the responsibility of Medi-Cal managed care plans and the Fee for Service delivery system for covering non-specialty mental health services. (BHIN 21-073).

A. Pursuant to W&I Code section 14184.402(a) the following definitions of "medical necessity" or "medically necessary" apply:

1) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in W&I Code section 14059.5.

2) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services needed to correct and ameliorate mental illness and conditions. Federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a mental health condition. All mental health services that are not covered under Medi-Cal Fee For Service (FFS) or by Managed Care Plans as non-specialty mental health services as established in W&I Code section 14184.402(b) that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services and the Contractor shall cover them for members who meet the criteria for access to the specialty mental health delivery system.

Exhibit A – Attachment 2
SCOPE OF SERVICES

Services provided to a member must be medically necessary and clinically appropriate to address the member's presenting condition.

B. Criteria for Adult Members to Access the Specialty Mental Health Services Delivery System

For members 21 years of age or older, the Contractor shall provide covered specialty mental health services for members who meet both of the following criteria, (1) and (2) below:

1. The member has one or both of the following:
    a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
    b. A reasonable probability of significant deterioration in an important area of life functioning

AND

2. The member's condition as described in paragraph (1) is due to either of the following:
    a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
    b. A suspected mental disorder that has not yet been diagnosed

C. Criteria for Members under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled members under 21 years of age, Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled members who meet either of the following criteria:

1) The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool

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SCOPE OF SERVICES

approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

2) The member meets both of the following requirements in a and b below:
   a. The member has at least one of the following:
      i. A significant impairment
      ii. A reasonable probability of significant deterioration in an important area of life functioning
      iii. A reasonable probability of not progressing developmentally as appropriate
      iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

AND

   b. The member's condition as described in subparagraph (A) is due to one of the following:
      i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
      ii. A suspected mental health disorder that has not yet been diagnosed
      iii. Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional

2. Provision of Services

A. The Contractor shall provide or arrange, and pay for, the following medically necessary covered specialty mental health services to members who meet access criteria for receiving specialty mental health services. See Exhibit E, Attachment 2, Service Definitions, for detailed descriptions of the specialty mental health services listed below:

1) Mental health Services;

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2) Medication Support Services;

3) Day Treatment Intensive;

4) Day Rehabilitation;

5) Crisis Intervention;

6) Crisis Stabilization;

7) Adult Residential Treatment Services;

8) Crisis Residential Treatment Services;

9) Psychiatric Health Facility Services;

10) Intensive Care Coordination (for members under the age of 21);

11) Intensive Home Based Services (for members under the age of 21);

12) Therapeutic Behavioral Services (for members under the age of 21);

13) Therapeutic Foster Care (for members under the age of 21);

14) Psychiatric Inpatient Hospital Services;

15) Targeted Case Management;

16) Peer Support Services (If the Contractor has opted to provide Peer Support Services and has been approved by DHCS, the Contractor shall comply with the peer support services provisions in Attachment 15); ~~and~~

17) For members under the age of 21, the Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code (W&I Code § 14184.402 (d)); and

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18) Community-Based Mobile Crisis Intervention Services (also referred to as “Mobile Crisis Services”) (BHIN 23-025).

B. Medi-Cal Managed Care Plan members receive mental health disorder benefits in every classification - inpatient, outpatient, prescription drug and emergency - that the members receive medical/surgical benefits, in compliance with 42 C.F.R. section 438.910(b)(2). The Contractor is only required to provide inpatient and outpatient specialty mental health services, as provided for in this Contract and as required pursuant to section 1396d(r) of Title 42 of the United States Code, as prescription drug and emergency benefits are provided through other delivery systems. Emergency and post-stabilization services described in 42 C.F.R. § 438.114 are not provided as specialty mental health services covered by Contractor. Emergency and post-stabilization services for all Medi-Cal members are covered through the capitation payment made to Medi-Cal Managed Care Plans or through fee-for-service. Contractor shall provide psychiatric inpatient hospital services, psychiatric health facilities services, crisis intervention, crisis stabilization, and crisis residential services and comply with relevant provisions for emergency admission to a psychiatric inpatient hospital as required by Attachment 3 of Exhibit A to this Agreement; however, this is not equivalent to emergency services described in 42 CFR § 438.114. Medi-Cal Managed Care Plans shall cover and pay for emergency room professional services pursuant to Cal. Code Regs., tit. 22 §53855, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition, and, if an emergency medical condition exists, for all services medically necessary to stabilize the member. Managed Care Plans shall cover and pay for facility charges for emergency room visits (BHIN 22-011 and APL 22-005).

C. Services shall be provided, in accordance with the State Plan, to members, who meet criteria to access SMHS, documented in accordance with state and federal requirements.

D. The Contractor shall provide or arrange and pay for all medically necessary covered specialty mental health services in a sufficient amount, duration, and scope to reasonably achieve the purpose for which the

Exhibit A – Attachment 2
SCOPE OF SERVICES

services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered specialty mental health service solely because of diagnosis, type of illness, or condition of the member. The Contractor may deny services based on W&I Code sections 14184.402, subdivisions (a), (c), and (d), 14059.5; and departmental guidance and regulation. (42 C.F.R. § 438.210(a)(2) and (3).)

E. The Contractor shall make all medically necessary covered specialty mental health services available in accordance with Cal. Code Regs., tit. 9, sections1810.345, 1810.350 and 1810.405, and 42 Code of Federal Regulations part 438.210.

F. The Contractor shall provide second opinions from a network provider or arrange for the member to obtain a second opinion outside the network, at no cost to the member. (42 C.F.R § 438.206(b).) At the request of a member when the Contractor or its network provider has determined that the member is not entitled to specialty mental health services due to not meeting the criteria for access to SMHS, the contractor shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (Cal. Code Regs., tit. 9, § 1810.405(e).)

G. The Contractor shall provide a member's choice of the person providing services to the extent feasible in accordance with Cal. Code Regs., tit. 9, section 1830.225 and 42 Code of Federal Regulations part 438.3(l).

3. Requirements for Day Treatment Intensive and Day Rehabilitation

A. The Contractor shall require providers to request prior authorization for day treatment intensive and day rehabilitation services, in accordance with Information Notice 22-016 and any subsequent departmental notices.

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

C. The Contractor shall require that providers include, one or more of the following day treatment intensive and day rehabilitation service components: assessment, treatment planning, therapy, psychosocial rehabilitation. Both services must have a clearly established site for

Exhibit A – Attachment 2
SCOPE OF SERVICES

services although all services need not to be delivered at that site and some service components may be delivered through telehealth or telephone.

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

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

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

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

E. The Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the member is present for at least 50 percent of scheduled hours of operation for that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the member's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

F. <u>Documentation Standards.</u> The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation requirements in BHIN 22-019.

Exhibit A – Attachment 2
SCOPE OF SERVICES

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

H. Written Program Description. The Contractor shall ensure there is a written program description for day treatment intensive and day rehabilitation. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this section. The Contractor shall review the written program description for compliance with this section with prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

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

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

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

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

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

4. Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) are specialty mental health services covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). (Cal. Code Regs., tit. 9, § 1810.215.) TBS are intensive, one-to-one services designed to help members and their parents/caregivers manage specific behaviors using short-term measurable goals based on the member's needs. TBS is described in the Department of Mental Health Information Notice 08-38.

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

1. Provider Compensation

The Department shall ensure that no payment is made to a network provider other than by the Contractor for services covered under this agreement, except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR chapter IV. (42 C.F.R. § 438.60.)

2. Payments for Indian Health Care Providers

A. The Contractor shall make payment to all Indian Health Care Providers (IHCPs) (42 CFR § 438.14(a)) in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46 including paying 90% of all clean claims from practitioners within 30 days of the date of receipt and paying 99 percent of all clean claims from practitioners within 90 days of the date of receipt. (42 C.F.R. § 438.14(b)(2).)

B. The Contractor shall pay an IHCP that is not enrolled as a FQHC, regardless of whether it is a network provider of the Contractor, its applicable encounter rate published annually in the Federal Register by the Indian Health Service or in the absence of a published encounter rate, the amount the IHCP would receive if the services were provided under the State plan's fee-for-service methodology. (42 C.F.R. § 438.14 (c)(2).)

C. The Contractor shall comply with guidance issued by DHCS regarding Payments for Indian Health Care Providers, including BHIN 22-020 and any subsequent information notices.

D. To initiate payment, Contractor shall require IHCPs to submit claims in accordance with claiming requirements. The rate on the claim should reflect the rate the IHCP should be paid for the service in accordance with Department guidance. If the rate claimed is incorrect for any reason, the amount due to the IHCP from Contractor shall be consistent with the guidance in BHIN 22-020 and subsequent information notices. Contractor shall pay claims from IHCPs in accordance with the timeliness requirements in 42 CFR §§ 438.14(b)(2)(iii), 447.45, and 447.46.

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

3. Prohibited Payments

A. Federal Financial Participation is not available for any payment amount for services furnished by an excluded individual or entity, or at the direction of a physician during the period such physician is excluded when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the Department failed to suspend payments during an investigation of a credible allegation of fraud. (42 U.S.C. § 1396b(i)(2).)

B. In accordance with Section 1903(i) of the Social Security Act, the Contractor is prohibited from paying for an item or service:

1) Furnished under this Contract by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.

2) Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

3) Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

4) With respect to any services or activities furnished for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4. Emergency Admission for Psychiatric Inpatient Hospital Services

The Contractor shall comply with Cal.Code Regs. Tit. 9 § 1820.225 regarding emergency admission for psychiatric inpatient hospital services regarding authorization and payment for both contract and non-contract hospitals.

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

5. Audit Requirements

The Contractor shall submit audited financial reports specific to this Contract on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. (42 C.F.R. § 438.3(m).)

6. Recovery of Overpayments

A. The Contractor, and any subcontractor or any network provider of the Contractor, shall report to the Department within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services. (42 C.F.R. § 438.608(c)(3).)

B. The Contractor, or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures that include provision for the suspension of payments to a network provider for which the State, or the Contractor, determines there is a credible allegation of fraud. (42 C.F.R. §§ 438.608(a)(8) and 455.23.)

C. The Contractor shall specify the retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. The policy shall specify the process, timeframes, and documentation required for reporting the recovery of all overpayments. The Contractor shall require its network providers to return any overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified. The Contractor shall also specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments. Contractor shall comply with the reporting requirements, and other requirements, in BHIN 19-034. (42 C.F.R. § 438.608(d).)

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

7. Physician Incentive Plans

A. The Contractor shall obtain approval from the Department prior to implementing a Physician Incentive Plan between the Contractor and a subcontractor (Cal. Code Regs. tit. 9, § 1810.438(h).).

1) Pursuant to 42 Code of Federal Regulations part 438.3(i), the Contractor shall comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210.

2) Specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member. (42 C.F.R. § 422.208(c)(1).)

3) If a physician or physician group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual member surveys. (42 C.F.R. §§ 422.208(c)(2).)

4) The Contractor shall provide information on its Physician Incentive Plan to any Medicaid member upon request (this includes the right to adequate and timely information on a Physician Incentive Plan). Such information shall include: whether the Contractor uses a physician incentive plan that affects the use of referral services, (2) the type of incentive arrangement, and (3) whether stop-loss protection is provided. (42 C.F.R. § 422.210(b).)

8. Financial requirements

A. The Contractor shall not impose financial requirements or cumulative financial requirements, as defined in 42 C.F.R. section 438.900, for any member receiving specialty mental health services.

10. ICD- 10

A. The Contractor shall use the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or current edition, as the clinical tool to make diagnostic determinations.

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

~~B.~~ Once a DSM-5 mental health disorder diagnosis is determined, the Contractor shall determine the corresponding mental health diagnosis, in the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), or current edition. The Contractor shall use the ICD-10 diagnosis code(s) to submit a claim for specialty mental health services to receive reimbursement of Federal Financial Participation (FFP).

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

1. Health Information Systems

A. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. (42 C.F.R. § 438.242(a); Cal. Code Regs., tit. 9, § 1810.376.) The system shall provide information on areas including, but not limited to, utilization, claims, grievances, and appeals. (42 C.F.R. § 438.242(a).) The Contractor shall comply with Section 6504(a) of the Affordable Care Act which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Social Security Act. (42 C.F.R. § 438.242(b)(1).)

B. The Contractor's health information system shall, at a minimum:

1) Collect data on member and provider characteristics as specified by the Department, and on services furnished to members as specified by the Department; (42 C.F.R. § 438.242(b)(2).)

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

a. Verifying the accuracy and timeliness of reported data, including data from network providers compensated on the basis of capitation payments; (42 C.F.R. § 438.242(b)(3)(i).)

b. Screening the data for completeness, logic, and consistency; and (42 C.F.R. § 438.242(b)(3)(ii).)

c. Collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts. (42 C.F.R. § 438.242(b)(3)(iii).)

3) Make all collected data available to the Department and, upon request, to CMS. (42 C.F.R. § 438.242(b)(4).)

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

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

2. Encounter Data

The Contractor shall submit encounter data to the Department at a frequency and level specified by the Department and CMS. (42 C.F.R. § 438.242(c)(2).) The Contractor shall ensure collection and maintenance of sufficient member encounter data to identify the provider who delivers service(s) to the member. (42 C.F.R. § 438.242(c)(1).) The Contractor shall submit all member encounter data that the Department is required to report to CMS under § 438.818. (42 C.F.R. § 438.242(c)(3).) The Contractor shall submit encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. (42 C.F.R. § 438.242(c)(4).)

3. Interoperability Rule Patient Access Application Programming Interface

In compliance with the terms of BHIN 22-068 or further guidance issued by the Department, Contractor shall implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) and a publicly accessible, standards-based Provider Directory API that can connect to mobile applications and be available through a public-facing digital endpoint on Contractor's website. (45 C.F.R. § 170.215; 42 C.F.R. §§ 431.60, 431.70, and 438.10, 438.242.)

4. MEDSLITE Access

The Contractor shall perform the following:

A. Establish County Behavioral Health MEDSLITE Coordinators (MEDSLITE Coordinators) to work with DHCS. These MEDSLITE Coordinators are required to sign and submit an Oath of Confidentiality to DHCS. Only these designated MEDSLITE Coordinators may initiate requests to add, delete, or otherwise modify a MEDSLITE user account. These MEDSLITE Coordinators are responsible for maintaining an active list of the Contractor's users with MEDSLITE access and collecting a signed MEDSLITE Oath of Confidentiality from each user. The MEDSLITE Coordinators are responsible for ensuring users are informed they cannot

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

share user accounts, that MEDSLITE is to be used for only authorized purposes, and that all activity is logged. The MEDSLITE Coordinators may be changed by written notice to DHCS. They should be employees at an appropriate level in the organization, with sufficient responsibility to carry out the duties of this position. The MEDSLITE Coordinators will provide, assign, delete, and track user login identification information for authorized staff members. They are responsible for ensuring processes are in place which result in prompt MEDSLITE account deletion requests when the Contractor's users leave employment or no longer require access due to change in job duties.

B. Ensure that information furnished or secured via MEDSLITE shall be used solely for the purposes described in this Agreement. The information obtained from MEDSLITE shall be used exclusively to administer the Medi-Cal program. The Contractor further agrees that information obtained under this Agreement will not be reproduced, published, sold, or released in original or any other form for any purpose other than identified in this Agreement.

C. Ensure that any agents, including a subcontractor, (if prior approval is obtained from DHCS) to whom they provide DHCS data, agree in writing to the same requirements for privacy and security safeguards for confidential data that apply to the Contractor with respect to this Agreement. The Contractor shall seek prior written approval from DHCS before providing DHCS data to a subcontractor.

D. Adhere to security and confidential provisions outlined in Exhibit F, the Privacy and Security Provisions for the protection of any information exchanged between Contractor Name and the DHCS.

E. During the term of this Agreement, the Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident involving DHCS data following the process outlined within Section 17 of Exhibit F, the Privacy and Security Provisions of this Agreement.

F. In order to enforce this MEDSLITE Access provision, the Contractor agrees to assist DHCS in performing compliance assessments. These assessments may involve compliance review questionnaires, and/or review of the facilities, systems, books, and records of the Contractor, with

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

reasonable notice from DHCS. Such reviews shall be scheduled at times that take into account operational and staffing demands. The Contractor agrees to promptly remedy all violations of any provision of this Agreement and certify the same to DHCS in writing, or to enter into a written Corrective Action Plan with DHCS containing deadlines for achieving compliance with specific provisions of this Agreement.

5. 274 Provider Network Data Reporting

A. The Contractor is required to submit provider network data to DHCS using the 274 standard on a monthly basis and must be submitted between the 1st and 10th of each month. (42 C.F.R. 438.207(a))

B. The Contractor shall complete data submission pursuant to DHCS BHIN 22-032 and any subsequent guidance issued by the department.

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

1. Quality Assessment and Performance Improvement

A. The Contractor shall implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it furnishes to members. (42 C.F.R. § 438.330 (a).)

B. The Contractor's QAPI Program shall improve the Contractor's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

C. The Contractor shall have a written description of the QAPI Program that clearly defines the QAPI Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The Contractor shall evaluate the impact and effectiveness of its QAPI Program annually and update the Program as necessary per Cal. Code Regs., tit. 9, § 1810.440(a)(6). (42 C.F.R. § 438.330(e)(2).)

D. The QAPI Program shall include collection and submission of performance measurement data required by the Department, which may include performance measures specified by CMS. The Contractor shall measure and annually report to the Department its performance, using the standard measures identified by the Department. (42 C.F.R. § 438.330 (a)(2), (b)(2), (c)(2).)

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

F. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services. (42 C.F.R. § 438.330(b)(3).)

G. The Contractor shall implement mechanisms to assess member/family satisfaction. The Contractor shall assess member/family satisfaction by:

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

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

2) Evaluating member grievances, appeals and State Hearings at least annually; and

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

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

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

I. The Contractor shall implement mechanisms to address meaningful clinical issues affecting members system-wide.

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

K. The Contractor's QAPI Program shall include Performance Improvement Projects as specified in paragraph 5.

2. Quality Improvement (QI) Work Plan

C. The Contractor shall have a Quality Improvement (QI) Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QI Work Plan shall include:

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

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

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

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

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

   b. Objectives, scope, and planned QI activities for each year; and,

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

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

5) Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Attachments 7 and 11.

3. Quality Improvement (QI) Committee and Program

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

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

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

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

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

E. The QI Program shall include active involvement in the planning, design and execution of the QI Program by the Contractor's practitioners and providers, members who have accessed specialty mental health services through the Contractor, family members, legal representatives, or other persons similarly involved with members as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(2)(A-C).

F. QI activities shall include:

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

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

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

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

5) Designing and implementing interventions for improving performance;

6) Measuring effectiveness of the interventions;

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

8) Reviewing member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

4. External Quality Review

The Contractor shall undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

5. Performance Improvement Projects

A. The Contractor shall conduct a minimum of two Performance Improvement Projects (PIPs) per year, including any PIPs required by DHCS or CMS. DHCS may require additional PIPs. One PIP shall focus on a clinical area and one on a non-clinical area. (42 C.F.R. § 438.330(b)(1) and (d)(1).) Each PIP shall:

1) Be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction;

2) Include measurement of performance using objective quality indicators;

3) Include implementation of interventions to achieve improvement in the access to and quality of care;

4) Include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; and,

5) Include planning and initiation of activities for increasing or sustaining improvement. (42 C.F.R. § 438.330(d)(2).)

B. The Contractor shall report the status and results of each performance improvement project to the Department as requested, but not less than once per year. (42 C.F.R. § 438.330(d)(3).)

6. Practice Guidelines

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

A. The Contractor shall adopt practice guidelines. (42 C.F.R. § 438.236(b) and Cal. Code Regs., tit. 9, § 1810.326)

B. Such guidelines shall meet the following requirements:

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

2) They consider the needs of the members;

3) They are adopted in consultation with network providers; and

4) They are reviewed and updated periodically as appropriate. (42 C.F.R. § 438.236(b).)

C. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. (42 C.F.R. § 438.236(c).)

D. The Contractor shall take steps to assure that decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines. (42 C.F.R. § 438.236(d).)

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

1. Utilization Management

A. The Contractor shall operate a Utilization Management Program that is responsible for assuring that members have appropriate access to specialty mental health services as required in Cal. Code Regs., tit. 9, section 1810.440(b)(1)-(3).

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

C. Compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. (42 C.F.R. § 438.210(e).)

D. The Contractor may place appropriate limits on a service based on criteria applied under the State Plan, such as criteria for access to SMHS and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration and scope to reasonably achieve the purpose for which the services are furnished. (42 C.F.R. § 438.210(a)(4)(i), (ii)(A).)

E. The Contractor shall not impose quantitative treatment limitations, aggregate lifetime or annual dollar limits as defined in 42 C.F.R. 438.900, for any member receiving specialty mental health services.

F. The Contractor shall not impose non-quantitative treatment limitations for specialty mental health services in any benefit classification (i.e., inpatient and outpatient) unless the Contractor's policies and procedures have been determined by the Department to comply with Title 42 of the Code of Federal Regulations, subpart K. (42 C.F.R. § 438.910(d).)

G. The Contractor shall submit to the Department, upon request, any policies and procedures or other documentation necessary for the State to establish and demonstrate compliance with Title 42 of the Code of Federal Regulations, part 438, subpart K, regarding parity in mental health and substance use disorder benefits.

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

2. Service Authorization

A. Contractor shall implement mechanisms to assure authorization decision standards are met in accordance with Behavioral Health Information Notices (BHINs) 22-016 and 22-017, or any subsequent Departmental notices issued to address parity in mental health and substance use disorder benefits subsequent to the effective date of this contract, and any applicable state and federal regulations. (42 C.F.R. § 438.910(d).) The Contractor shall:

1) Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. (42 C.F.R. § 438.210(b)(1).)

2) Have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. (42 C.F.R. § 438.210(b)(2)(i-ii).)

3) Have any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in addressing the member's behavioral health needs. (42 C.F.R. § 438.210(b)(3).)

4) Notify the requesting provider and give the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 C.F.R. § 438.210(c)) The member's notice shall meet the requirements in Attachment 12, Section 10, paragraph A and Section 9, paragraph J and be provided within the timeframes set forth in Attachment 12, Section 10, paragraph B and Section 9, paragraph H.

B. The Contractor shall comply with authorization timeframes in accordance with BHINs 22-016 and 22-017, or any subsequent Departmental notices issued to address parity in mental health and substance use disorder benefits subsequent to the effective date of this contract, as well as any applicable state and federal regulations. (42 C.F.R. § 438.910(d).)

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

C. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. The Contractor may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the Department upon request), and documents, a need for additional information and how the extension is in the member's interest. (42 C.F.R. § 438.210(d)(2))

D. The Contractor shall act on an authorization request for treatment for urgent conditions within one hour of the request. (Cal. Code Regs., tit. 9, §§ 1810.253 1810.405, subd. (c)).

E. The Contractor shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary. (Cal. Code Regs., tit. 9, §§ 1820.200(d) and 1820.225).

D. The Contractor shall define service authorization request in a manner that at least includes a member's request for the provision of a service. (42 C.F.R. § 431.201)

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

1. Member **Enrollment**

A. Medi-Cal eligible members are automatically enrolled in the single MHP in their county. (1915(b) waiver, § A, part I, para. C, p. 31.)

B. The Contractor shall be responsible for providing or arranging and paying for specialty mental health services for Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to specialty mental health services. (Cal. Code Regs. tit. 9, §1810.228.) The Contractor shall accept these individuals in the order in which they are referred (including self-referral) without restriction (unless authorized by CMS), up to the limits set under this Contract. (42 C.F.R. § 438.3(d)(1).)

C. The Contractor shall not, on the basis of health status or need for health care services, discriminate against Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to specialty mental health services. (42 C.F.R. § 438.3(d)(3).)

D. The Contractor shall not unlawfully discriminate against Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to specialty mental health services on the basis of race, color, national origin, sex, sexual orientation, gender, gender identity, religion, marital status, ethnic group identification, ancestry, age, medical condition, genetic information, mental disability, or physical disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender, gender identity, religion, marital status, ethnic group identification, ancestry, age, medical condition, genetic information, mental disability, or physical disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(4); 45 C.F.R. § 92.2; Gov. Code § 11135(a); W&I Code § 14727(a)(3).)

2. Cultural Competence

A. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. (42 C.F.R. § 438.206(c)(2).)

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

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

3. Out-of-Network Services

A. The Contractor's provider network is unable to provide necessary services within the time, distance, and timely access standards, covered under this Contract, to a particular member, the Contractor shall allow members to access the services and adequately and timely cover the services out-of-network, for as long as the Contractor's provider network is unable to provide them and in accordance with state and federal law, this contract, and Department information notices, including BHIN 21-008, and any subsequent notices. (42 C.F.R. § 438.206(b)(4).)

B. In cases where an out-of-network provider is not available within the time and distance standards, Contractor shall arrange for telehealth or transportation to an in-person visit. Contractor shall ensure that members have the right to an in-person visit if they do not want to accept a telehealth visit. Contractor shall ensure that services rendered by out-of-network providers, including those provided within a Department approved alternative access standard, comply with timely access standards.

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

D. The Contractor shall comply with the requirements of Cal. Code Regs., tit. 9, section 1830.220 regarding providing members access to out-of-network providers when a provider is available in Contractor's network.

E. Pursuant to Department guidance, the Contractor shall submit to the Department for approval policies and procedures regarding authorization of out-of-network services to establish compliance with title 42 of the Code of Federal Regulations, section 438.910(d)(3).

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

4. Foster Children Placed Out-of-County

A. The Contractor shall authorize, pay, provide or arrange for medically necessary specialty mental health services for foster children placed outside of their counties of origin in accordance with W&I Code section 14717.1 and 14717.2 and pursuant to Department information notices.

B. The Contractor shall follow Mental Health and Substance Use Disorder (MHSUDS) IN 17-032, 18-027, BHIN 19-041, and any subsequent Information Notices. These Information Notices include standardized templates that the Contractor may use or adapt to the Contractor's needs.

5. Children in Adoption Assistance Program (AAP) and Kinship Guardian Assistance Payment (Kin-GAP)

A. The Contractor shall provide or arrange for the provision of medically necessary specialty mental health services to a child in the Adoption Assistance Program (AAP) residing within their adoptive parents' county of residence in the Contractor's county. These services are to be provided in the same way as the Contractor would provide services to any other child for whom the Contractor's county is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS). When treatment authorization requests are required, the Contractor shall be responsible for submitting treatment authorization requests to the mental health plan in the child's county of origin. (W&I Code § 16125.)

B. The Contractor shall provide or arrange for the provision of medically necessary specialty mental health services to a child in the Kinship-Guardian Assistance Program (Kin-GAP) residing within their legal guardian's county of residence in the Contractor's county. These services are to be provided in the same way that the Contractor would provide services to any other child for whom the Contractor ~~county~~ is listed as the county of responsibility on the MEDS. When treatment authorization requests are required, the Contractor shall be responsible for submitting treatment authorization requests to the mental health plan in the child's county of origin. (W&I Code § 11376.)

C. When the Contractor is the mental health plan in the county of origin for a child in AAP residing out-of-county with their adoptive parents (W&I Code

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

§ 16125) or a child in Kin-GAP residing out-of-county with their legal guardian (W&I Code § 11376) the Contractor shall be responsible for authorization and reauthorization of services for the child utilizing an expedited treatment authorization process that meets the authorization requirements set forth in MHSUDS Information Notice 22-016 and any applicable Departmental notices issued after the effective date of this contract.

D. The Contractor shall comply with timelines specified in Cal. Code Regs., tit. 9, § 1830.220(b)(4)(A)(1-3) and requirements set forth in MHSUDS Information Notice 22-016 and any applicable Departmental notices issued after the effective date of this contract, when processing or submitting authorization requests for children in AAP, or Kin-GAP, living outside their county of origin.

6. American Indian/Alaskan Native Members

A. The Contractor shall permit American Indian/Alaskan Native (AI/AN) members to receive services from any Indian health care provider (IHCP) participating as a network provider, to choose that IHCP as their provider, as long as that provider has capacity to provide the services. MHPs must reimburse MHP-certified IHCPs for the provision of these services to AI/AN Medi-Cal members whether or not the IHCP has a current contract with the member's county of responsibility. (42 C.F.R. § 438.14(b)(2),(4).)
B. The Contractor shall demonstrate it has sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for AI/AN members who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).)
C. The Contractor shall document good-faith efforts to contract with all IHCPs in the Contractor's county. If the Contractor does not contract with a IHCP in the Contractor's county, the Contractor must submit a written explanation to the Department of why it failed to contract with that IHCP, with supporting documentation as provided for in BHIN 23-041.
D. The Contractor shall permit Indian members to obtain covered services from out-of-network IHCPs if the members are otherwise eligible to receive such services. (42 C.F.R. § 438.14(b)(4).) The Contractor shall permit an out-of-network IHCP to refer an Indian member to a network provider. (42 C.F.R. § 438.14(b)(6).)

Exhibit A – Attachment 8
PROVIDER NETWORK

1. Enrollment and Screening

A. The Contractor shall ensure that all network providers are enrolled with the state as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 Code of Federal Regulations part 455, subparts B and E. (42 C.F.R. § 438.608(b).)

B. The Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected members. (42 C.F.R. § 438.602(b)(2).)

2. Assessment of Capacity

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

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

3. Network Adequacy

A. The Contractor shall ensure that all services covered under this Contract are available and accessible to members in a timely manner and without utilizing waitlists (42 C.F.R. § 438.206(a)).

B. Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible

equipment for Medi-Cal members with physical or mental disabilities. (42 C.F.R. § 438.206(b)(1) and (c)(3).)

C. The Contractor shall adhere to, in all geographic areas within the county, the time and distance standards for adult and pediatric mental health providers, as specified in BHIN 21-023 and its enclosures, or in subsequent guidance issued by the Department. (42 C.F.R. § 438.68(a), (b)(1)(iii), (3), 438.206(a); W&I Code § 14197.)

D. The Contractor may submit to the Department a request for Alternate Access Standards. The Department will evaluate requests and grant appropriate exceptions to the state developed standards, as specified in BHIN 21-023 and its enclosures, or in subsequent guidance issued by the Department. (42 C.F.R. § 438.68(a), (d), 438.206(a); W&I Code § 14197).

E. The Contractor shall comply with all network adequacy standards developed by the Department to implement 42 C.F.R. section 438.68, 438.206, and 438.207, including time and distance standards, timely access, capacity and composition standards, and other network capacity requirements, as specified in BHIN 21-023 and its enclosures, or in subsequent guidance issued by the Department.

4. Timely Access

A. Timely Access. In accordance with 42 C.F.R. section 438.206(c)(1), the Contractor shall:

1) Meet and require network providers to meet standards for timely access to care and services, without utilizing waitlists taking into account the urgency of need for services, pursuant to W&I Code section 14197(d), as specified in BHIN 23-041 and its enclosures, or in subsequent, guidance issued by the Department.

a) Contractor shall ensure that members are offered appointments within the following timeframes:

i. Urgent care appointment for services that do not require prior authorization: within 48 hours of request.

ii. Urgent care appointment for services that require prior authorization: within 96 hours of request.

iii. Nonurgent appointments with a psychiatrist: within fifteen (15) business days of request.

iv. Nonurgent appointments with a nonphysician mental health care provider: within ten (10) business days of request.

v. Nonurgent follow-up appointment with a nonphysician mental health care provider: within ten (10) business days of the prior appointment for members undergoing a course of treatment for an ongoing mental health condition. This does not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care provider to once every ten (10) business days.

b) Urgent care appointments must be offered when a member has a condition that requires prompt attention, such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function. In accordance with Cal. Code Regs., tit. 9, section 1810.405, subdivision (c), Contractor shall have a statewide toll-free telephone number available 24 hours a day, seven days per week, to act on payment authorization requests for services to treat a member's urgent condition and shall respond to these requests within one hour of the request.

c) The waiting time for a particular appointment may be extended if the referring or treating licensed health

care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

d) Appointments for periodic follow-up care and preventive services to prevent and detect disease, illness, injury, or other health conditions may be scheduled in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

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

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

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

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

6) Take corrective action if a network provider fails to comply with.

5. Documentation of Network Adequacy

A. The Contractor shall give assurances to the Department and provide supporting documentation that demonstrates Contractor has the capacity to serve the expected enrollment in its service area in accordance with BHIN 23-041 and its enclosures, or in subsequent guidance issued by the Department. (42 C.F.R. § 438.207(a); W&I Code § 14197(f).)

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B. The Contractor shall submit documentation to the Department, as specified in BHIN 21-023 and its enclosures, or in subsequent guidance issued by the Department to demonstrate that it complies with the following requirements:

1) Offers an appropriate range of specialty services that are adequate for the anticipated number of members for the service area.

2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. (42 C.F.R. § 438.207(b).)

C. The Contractor shall submit the documentation at the times specified in BHIN 21-023 and its enclosures, or in subsequent guidance issued by the Department, but no less frequently than the following:

1) At the time it enters into this Contract with the Department;

2) On an annual basis; and

3) Within 10 business days of a significant change in the Contractor's operations that would render the Contractor non-compliant with standards for network adequacy and capacity including, but not limited to, the following types of changes:

a) Changes in services;

b) Changes in benefits;

c) Changes in geographic service area;

d) Changes in the composition of or payments to the Contractor's provider network; or

e) Enrollment of a new population in the Contractor's county. (42 C.F.R. § 438.207(c).);

f) The Contractor is required to notify DHCS by email of one of the listed changes at MHSDFinalRule@dhcs.ca.gov.

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D. The Contractor shall include details regarding the change and the Contractor's plans to ensure members continue to have access to adequate services and providers.

6. Choice of Provider

The Contractor shall provide a member's choice of the person providing services to the extent possible and appropriate consistent with Cal. Code Regs., tit. 9, §1830.225 and 42 Code of Federal Regulations part 438.3(l).

7. Provider Selection

A. The Contractor shall have written policies and procedures for selection and retention of providers. (42 C.F.R. § 438.214(a).)

B. The Contractor's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 C.F.R. §§ 438.12(a)(2), 438.214(c).)

C. In all subcontracts with network providers, the Contractor must follow the Department's uniform credentialing and re-credentialing policy. The Contractor must follow a documented process for credentialing and re-credentialing of network providers. (42 C.F.R. §§ 438.12(a)(2), 438.214(b).)

D. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 C.F.R. § 438.214(d).)

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

F. The Contractor shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).)

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G. Paragraphs A-F, above, may not be construed to:

1) Require the Contractor to subcontract with providers beyond the number necessary to meet the needs of its members;

2) Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

3) Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. (42 C.F.R. § 438.12(b).)

H. Upon request, the Contractor shall demonstrate to the Department that its providers are credentialed as required by paragraph C. (42 C.F.R. § 438.206(b)(6)

I. The Contractor shall establish individual, group and organizational provider selection criteria as provided for in Cal. Code Regs., tit. 9, section 1810.435.

J. The Contractor shall only use licensed, registered, or waivered providers acting within their scope of practice for services that require a license, waiver, or registration. (Cal. Code Regs., tit. 9, § 1840.314(d).)

K. The Contractor is not located outside of the United States. (42 C.F.R. § 602(i).)

8. Provider Certification

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

B. The Contractor shall comply with the provisions of 42 Code of Federal Regulations, sections parts 455.104, 455.105, 1002.203 and 1002.3, which relate to the provision of information about provider business

transactions and provider ownership and control, prior to entering into a contract and during certification or re-certification of the provider.

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

D. The Contractor shall certify or use another mental health plan's certification documents to certify, the organizational providers that subcontract with the Contractor to provide covered services in accordance with Cal. Code Regs., tit. 9, section 1810.435, and the requirements specified prior to the date on which the provider begins to deliver services under the contract, and once every three years after that date. The on-site review required by Cal. Code Regs., tit. 9, 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 members, except that on-site review is not required for public school or satellite sites.

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

F. The Contractor may allow an organizational provider to continue delivering covered services to members 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.

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

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PROVIDER NETWORK

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 members and staff.

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

6) The organizational provider maintains client records in a manner that meets the requirements of the Contractor, the requirements of Attachment 10; and applicable state and federal standards.

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

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

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

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

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

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

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

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

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

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.

H. 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 Attachment 2, Section 3 of this exhibit.

I. When an on-site review of an organizational provider would not otherwise be required and the provider offers day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Attachment 2, Section 3 of this exhibit.

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PROVIDER NETWORK

J. On-site review is required for hospital outpatient departments which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.

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

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

1) The provider makes major staffing changes.

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

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

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

5) There is a change of ownership or location.

6) There are complaints regarding the provider.

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

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

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N. In addition, Contractor may accept the certification of a provider by another Mental Health Plan, or by the Department, in order to meet the Contractor's obligations under Attachment 8, Sections 7 and 8. However, regardless of any such delegation to a subcontracting entity or acceptance of a certification by another MHP, Contractor shall remain ultimately responsible for adequate performance of all duties and obligations under this contract.

9. Provider Member Communications

A. The Contractor shall not prohibit nor otherwise restrict, a licensed, waivered, or registered professional, as defined in Cal. Code Regs., tit. 9, sections 1810.223 and 1810.254, who is acting within the lawful scope of practice, from advising or advocating on behalf of a member for whom the provider is providing mental health services for any of the following:

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

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

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

4) The member right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (42 C.F.R. § 438.102(a)(1).)

10. Provider Notifications

A. The Contractor shall inform providers and subcontractors, at the time they enter into a contract, about:

1) Member grievance, appeal, and State Hearing procedures and timeframes as specified in 42 C.F.R. sections 438.400 through 438.424.

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2) The member right to file grievances and appeals and the requirements and timeframes for filing.

3) The availability of assistance to the member with filing grievances and appeals.

4) The member's right to request a State Hearing after the Contractor has made a determination on a member's appeal, which is adverse to the member.

5) The member's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or State Hearing filing, if filed within the allowable timeframes, although the member may be liable for the cost of any continued benefits while the appeal or State Hearing is pending if the final decision is adverse to the member.

Exhibit A – Attachment 9
DOCUMENTATION REQUIREMENTS

1. Documentation Standards

   A. The Contractor shall implement and comply with documentation standards as set forth in guidance issued by the Department in BHIN 23-068.

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

1. Coordination of Care

A. The Contractor shall implement procedures to deliver care to and coordinate services for all of its members. (42 C.F.R. § 438.208(b).) These procedures shall meet Department requirements and shall do the following:

1) Ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member shall be provided information on how to contact their designated person or entity. (42 C.F.R. § 438.208(b)(1).)

2) Coordinate the services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. Coordinate the services the Contractor furnishes to the member with the services the member receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its members. (42 C.F.R. § 438.208(b)(2)(i)-(iv), Cal. Code Regs., tit. 9 § 1810.415.)

3) The Contractor shall share with the Department or other managed care entities serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. (42 C.F.R. § 438.208(b)(4).)

4) Ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. (42 C.F.R. § 438.208(b)(5).)

5) Ensure that, in the course of coordinating care, each member's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (42 C.F.R. § 438.208(b)(6).)

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COORDINATION AND CONTINUITY OF CARE

B. Consistent with the No Wrong Door policies set forth in W&I Code section 14184.402, the Contractor must cover the assessment and any SMHS provided during the assessment period for any member seeking care, even prior to the determination of a diagnosis, even prior to the determination of whether SMHS access criteria set forth in W&I Code section 14184.402(b)(2) are met, and even if the member is later determined to need non-specialty mental health services (NSMHS) and/or SUD services and is referred to the Medi-Cal Fee For Service delivery system or a Managed Care Plan for NSMHS or to the County Department responsible for SUD treatment. Contractor must cover SMHS even if the service was not included in the client plan, and even if the member has a co-occurring mental health condition and SUD.

C. As of the effective date identified by DHCS, the Contractor must use DHCS-approved standardized screening tools set forth in DHCS guidance (including standardized screening tools specific for adults and standardized screening tools specific for children and youth) to ensure members seeking mental health services who are not currently receiving covered SMHS or NSMHS are referred to the appropriate delivery system for mental health services, either in the Contractor network or the Managed Care Plan network, in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h).

D. If a member eligible for SMHS is also eligible for NSMHS during the course of receiving covered SMHS, the Contractor shall continue to cover non-duplicative, Medically Necessary SMHS even if the Member is simultaneously receiving NSMHS.

1) The Contractor must enter into a Memorandum of Understanding with any Medi-Cal Managed Care Plan serving the Contractor's members to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

2) If a member is receiving covered SMHS and is determined to meet the criteria for NSMHS covered by Medi-Cal Fee For Service and Managed Care Plans as defined by W&I Code section 14184.402, the Contractor must use DHCS-approved standardized transition tools set forth in DHCS guidance as required when members who have established relationships with contracted mental health providers experience a change in condition requiring NSMHS. Likewise, if a member is receiving NSMHS and is determined to meet the access criteria for SMHS as defined by W&I Code section

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

14184.402, the Contractor must use DHCS-approved standardized transition tools set forth in DHCS guidance as required when members who have established relationships with NSMHS providers experience a change in condition requiring SMHS. The Contractor must continue to cover the provision of medically necessary SMHS provided to a member who meets SMHS access criteria who is concurrently receiving NSMHS when those services are not duplicative and provide coordination of care with the Managed Care Plan.

3) The Contractor must develop and implement written policies and procedures to ensure that members meeting criteria for NSMHS, as indicated by a DHCS-approved standardized transition tool (including standardized transition tools specific for adults and standardized transition tools specific for children and youth), are referred to the Managed Care Plan or a Fee For Service provider offering NSMHS. Likewise, the Contractor must develop and implement written policies and procedures to ensure that members meeting access criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for children and youth) are referred by the Managed Care Plan to the Contractor.

E. The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's members. The Contractor shall ensure the components of the MOU comply with guidance issued by DHCS regarding MOU requirements. The MOU shall address how to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The MHP shall monitor the effectiveness of its MOU with Medi-Cal managed care plans. Should a conflict arise between the parties to the MOU, the Contractor shall abide by the requirements in BHIN 21-034. (Cal. Code Regs., tit. 9, § 1810.370.)

F. The Contractor shall implement a transition of care policy that is in accordance with applicable state and federal regulations, Mental Health and Substance Use Disorder Services Information Notice 18-059 and any Behavioral Health Information Notices issued by the Department for parity

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

in mental health and substance use disorder benefits subsequent to the effective date of this contract (42 C.F.R. § 438.62(b)(1)-(2).)

Exhibit A – Attachment 11
INFORMATION REQUIREMENTS

1. Basic Requirements

A. The Contractor shall provide information in a manner and format that is easily understood and readily accessible to members. (42 C.F.R. § 438.10(c)(1).) The Contractor shall provide all written materials for members in easily understood language, format, and alternative formats that take into consideration the special needs of members in compliance with 42 C.F.R. section 438.10(d)(6). The Contractor shall inform members that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. section 438.10.

B. The Contractor shall provide the required information in this section to each member when first receiving specialty mental health services and upon request. (1915(b) Medi-Cal Specialty Mental Health Services Waiver, § (2), subd. (d), at p. 26., attachments 3, 4; Cal. Code Regs., tit. 9, § 1810.360(e).)

C. The Contractor shall operate a website that provides the content required in this section and complies with the requirements in 42 C.F.R. section 438.10.

D. For consistency in the information provided to beneficiaries, the Contractor shall use the Department developed definitions for managed care terminology, including: appeal, excluded services, grievance, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, provider, skilled nursing care, and urgent care. (42 C.F.R. § 438.10(c)(4)(i).)

E. The Contractor shall use Department developed model member handbooks and member notices that describe the transition of care policies for members. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3).)

F. Member information required in this section may only be provided electronically by the Contractor if all of the following conditions are met:

1) The format is readily accessible;

2) The information is placed in a location on the Contractor’s website that is prominent and readily accessible;

3) The information is provided in an electronic form which can be electronically retained and printed;

4) The information is consistent with the content and language requirements of this Attachment; and

5) The member is informed that the information is available in paper form without charge upon request and Contractor provides it upon request within 5 business days. (42 C.F.R. § 438.10(c)(6).)

G. The Contractor shall have in place mechanisms to help members and potential members understand the requirements and benefits of the plan. (42 C.F.R. § 438.10(c)(7).)

2. Information Provided to Members

A. The Contractor shall provide information to members and potential members including, at a minimum, all of the following:

1) The basic features of managed care. (42 C.F.R. § 438.10(e)(2)(ii).)

2) The mandatory enrollment process. (42 C.F.R. § 438.10(e)(2)(iii).)

3) The service area covered by the Contractor. (42 C.F.R. § 438.10(e)(2)(iv).)

4) Covered benefits, including:

a. Which benefits are provided by the Contractor; and,

b. Which, if any, benefits are provided directly by the State.

5) The provider directory. (42 C.F.R. § 438.10(e)(2)(vi).)

6) Any cost-sharing that will be imposed by the Contractor consistent with the State Plan. (42 C.F.R. §§ 438.10(e)(2)(vii); State Plan § 4.18.)

7) The requirements for the Contractor to provide adequate access to covered services, including the network adequacy standards

established in 42 Code of Federal Regulations part 438.68. (42 C.F.R. § 438.10(e)(2)(viii).)

8) The Contractor's responsibilities for coordination of care. (42 C.F.R. § 438.10(e)(2)(ix).)

9) To the extent available, quality and performance indicators for the Mental Health Plan, including member satisfaction. (42 C.F.R. § 438.10(e)(2)(x).)

B. The Contractor shall make a good faith effort to give written notice of termination of a contracted provider, to each member who was seen on a regular basis by the terminated provider. The notice to the member shall be provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later. (42 C.F.R. § 438.10(f)(1).)

3. Language and Format

A. Nondiscrimination Requirements, Language Assistance, and Information Access for Individuals with Limited English Proficiency and/or Disabilities (42 CFR § 438.10; Government Code (Gov. Code) § 11135; 28 CFR §§ 35.160-35.164; 28 CFR § 36.303; 45 CFR § 92.101; 45 CFR § 92.102)

1) The Contractor shall comply with all applicable state and federal requirements regarding nondiscrimination, language assistance, information access, including but not limited to, the Dymally-Alatorre Bilingual Services Act, section 1557 of the Patient Protection and Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act.
2) Nondiscrimination Notice

i. The Nondiscrimination Notice must be sent in conjunction with each of the following significant notices sent to members:

a. Notices of Adverse Benefit Determination.

b. Grievance acknowledgement letter.

c. Appeal acknowledgement letter.

d. Grievance resolution letter.

e. Notice of Appeal Resolution.

ii. The Contractor shall post a Department-approved nondiscrimination notice that informs members, potential members, and the public about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the Contractor's compliance with the requirements.

iii. The nondiscrimination notice shall be posted in at least a 12-point font and be included in any documents that are vital or critical to obtaining services and/or benefits, and all other informational notices targeted to beneficiaries, potential members, and the public. Informational notices include not only documents intended for the public, such as outreach, education, and marketing materials, but also written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits.

iv. The nondiscrimination notice shall also be posted in at least a 12-point font in conspicuous physical locations where the Contractor interacts with the public, and on the Contractor's website in a location that allows any visitor to the website to easily locate the information.

v. The nondiscrimination notice shall include all legally required elements under the applicable subsections of Gov. Code section 11135.

vi. The nondiscrimination notice shall include information on how to file a discrimination grievance directly with the DHCS Office of Civil Rights, in addition to information about how to file a discrimination grievance with the County and the U.S. Health and Human Services Office for Civil Rights.

vii. The Contractor is not prohibited from posting the nondiscrimination notice in additional publications and communications.

3) Language Assistance Taglines

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i. The Language Assistance Taglines must be sent in conjunction with each of the following significant notices sent to members:

   a. Notices of Adverse Benefit Determination.

   b. Grievance acknowledgement letter.

   c. Appeal acknowledgement letter.

   d. Grievance resolution letter.

   e. Notice of Appeal Resolution.

ii. The Contractor shall post Department-approved taglines in a conspicuously visible size (no less than 12-point font), in English and at least the top 15 non-English languages in the State (as determined by the Department), informing members, potential members, and the public of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.

iii. Taglines shall be posted in any documents that are vital or critical to obtaining services and/or benefits, conspicuous physical locations where the Contractor interacts with the public, on the Contractor's website in a location that allows any visitor to the website to easily locate the information, and in all member information and other information notice, in accordance with federal and state requirements.

4) Effective Communication with Individuals with Disabilities

i. The Contractor shall comply with all applicable requirements of federal and state disability law and take appropriate steps to ensure effective communication with individuals with disabilities.

ii. The Contractor shall provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, including the provision of qualified interpreters and written materials in alternative formats, free

of charge and in a timely manner, when such aids and services are necessary to ensure that individuals with disabilities have an equal opportunity to participate in, or enjoy the benefits of, the Contractor's covered services, programs, and activities.

iii. The Contractor shall provide interpretive services and make member information available in the following alternative formats: Braille, audio format, large print (no less than 20-point font), and accessible electronic format (such as a data CD). In determining what types of auxiliary aids and services are necessary, the Contractor shall give "primary consideration" to the individual's request of a particular auxiliary aid or service.

iv. Auxiliary aids and services include:

a. Qualified interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

b. Qualified Readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

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4. Handbook

A. The Contractor shall provide members with a copy of the handbook and provider directory when the member first accesses services and thereafter upon request. (Cal. Code Regs., tit. 9, § 1810.360.)

B. The Contractor shall ensure that the handbook includes the current toll-free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week. (Cal. Code Regs., tit. 9, § 1810.405, subd. (d).)

C. The member handbook shall include information that enables the member to understand how to effectively use the managed care program. This information shall include, at a minimum:

1) Benefits provided by the Contractor. (42 C.F.R. § 438.10(g)(2)(i).)

2) How and where to access any benefits provided by the Contractor, including any cost sharing, and how transportation is provided. (42 C.F.R. § 438.10(g)(2)(ii).)

a) The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that members understand the benefits to which they are entitled. (42 C.F.R. § 438.10(g)(2)(iii).)

b) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's provider. (42 C.F.R. § 438.10(g)(2)(iv).)

c) Any restrictions on the member's freedom of choice among network providers. (42 C.F.R. § 438.10(g)(2)(vi).)

d) The extent to which, and how, members may obtain benefits from out-of-network providers. (42 C.F.R. § 438.10(g)(2)(vii).)

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e) Cost sharing, if any, consistent with the State Plan. (42 C.F.R. § 438.10(g)(2)(viii); State Plan § 4.18.)

f) Member rights and responsibilities, including the elements specified in § 438.100 as specified in Section 7 of this Attachment. (42 C.F.R. § 438.10(g)(2)(ix).)

g) The process of selecting and changing the member's provider. (42 C.F.R. § 438.10(g)(2)(x).)

h) Grievance, appeal, and State Hearing procedures and timeframes, consistent with 42 C.F.R. sections 438.400 through 438.424, in a state-developed or state-approved description. Such information shall include:

1) The right to file grievances and appeals;

The Contractor shall include information on filing a Discrimination Grievance with the Contractor, the Department's Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights, and shall specifically include information stating that the Contractor complies with all state and federal civil rights laws. If a member believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the Contractor, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights.

2) The requirements and timeframes for filing a grievance or appeal;

3) The availability of assistance in the filing process;

4) The right to request a State Hearing after the Contractor has made a determination on a member's appeal which is adverse to the member;

5) The fact that, when requested by the member, benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State Hearing within the timeframes specified for filing, and that the member may, consistent with state policy, be required to pay the cost of services furnished while the appeal or State Hearing is pending if the final decision is adverse to the member. (42 C.F.R. § 438.10(g)(2)(xi).)

i) How to exercise an advance directive, as set forth in 42 C.F.R. 438.3(j). (42 C.F.R. § 438.10(g)(2)(xii).)

j) How to access auxiliary aids and services, including additional information in in alternative formats or languages. (42 C.F.R. § 438.10(g)(2)(xiii).)

k) The Contractor's toll-free telephone number for member services, medical management, and any other unit providing services directly to members. (42 C.F.R. § 438.10(g)(2)(xiv).)

l) Information on how to report suspected fraud or abuse. (42 C.F.R. § 438.10(g)(2)(xv).)

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

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

2) Physician incentive plans as set forth in 42 C.F.R. section 438.3(i). (42 C.F.R. § 438.10(f)(3).)

D. The Contractor shall give each member notice of any significant change (as defined by the Department) to information in the handbook at least 30 days before the intended effective date of the change. (42 C.F.R. § 438.10(g)(4).)

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E. Consistent with 42 Code of Federal Regulations section 438.10(g)~~(3)~~ and Cal. Code Regs., tit. 9, section 1810.360, subdivision (e), the handbook will be considered provided if the Contractor:

1) Mails a printed copy of the information to the member's mailing address;

2) Provides the information by email after obtaining the member's agreement to receive the information by email;

3) Posts the information on the Contractor's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet addresses, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or,

4) Provides the information by any other method that can reasonably be expected to result in the member receiving that information.

5. Provider Directory

A. The Contractor must follow the Department's provider directory policy, which the Department implemented via Mental Health and Substance Use Disorder Services Information Notice 18-020, and other applicable Mental Health and Substance Use Disorder Services Information Notices that may be issued subsequent to the effective date of this contract.

B. The Contractor shall make provider directories available in electronic and paper form upon request, and maintain a publicly accessible standards-based Provider Directory API as described in 42 CFR section 431.70 and BHIN 22-068, and meet the same technical standards of the Patient Access API and ensure that the provider directories include the following information for all network providers, including each licensed, waivered, or registered mental health provider employed by the Contractor, each provider organization or individual practitioner contracting with the Contractor, and each licensed, waivered, or registered mental health provider employed by a provider organization to deliver Medi-Cal services:

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1) Information on the category or categories of services available from each provider. (42 C.F.R. § 438.10(h)(1)(v).)

2) The names, medical group/foundation, independent physician/provider associations, and any group affiliations, street addresses, telephone numbers, specialty, and website URLs of current contracted providers by category. (42 C.F.R. § 438.10(h)(1)(i)-(v).)

3) The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office. (42 C.F.R. § 438.10(h)(1)(vii).)

4) Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 C.F.R. § 438.10(h)(1)(viii).)

5) A means to identify which providers are accepting new members. (42 C.F.R. § 438.10(h)(1)(vi).)

6) Type of practitioner as appropriate.

7) National Provider Identifier number.

8) California License number and type of license.

9) Whether the provider has completed cultural competence training.

10) Hours and days when each services location is open, including the availability of evening and /or weekend hours.

C. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information. The Contractor shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory. (42 C.F.R. § 438.10(h)(3).)

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D. Provider directories shall be made available on the Contractor's website in a machine readable file and format as specified by the Secretary. (42 C.F.R. § 438.10(h)(4).)

6. Advance Directives

A. For purposes of this contract, advance directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the individual is incapacitated. (42 C.F.R. § 489.100.)

B. The Contractor shall maintain written policies and procedures on advance directives, which include a description of applicable California law. (42 C.F.R. §§ and 438.3(j)(1)-(3), 422.128.) Any written materials prepared by the Contractor for members 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. (42 C.F.R. § 438.3(j)(4).)

C. The Contractor shall provide adult members with the written information on advance directives. (42 C.F.R. § 438.3(j)(3).)

D. The Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. (42 C.F.R. §§ 422.128(b)(1)(ii)(F), 438.3(j).)

E. The Contractor shall educate staff concerning its policies and procedures on advance directives. (42 C.F.R. §§ 422.128(b)(1)(ii)(H), 438.3(j).)

7. Member Rights

A. The parties to this contract shall comply with applicable laws and regulations relating to patients' rights, including but not limited to W&I Code section 5325, Cal. Code Regs., tit. 9, sections 862 through 868, and 42 C. F. R. section 438.100. The Contractor shall ensure that its subcontractors comply with all applicable patients' rights laws and regulations.

B. The Contractor shall have written policies regarding the member rights specified in this section and ensure that its staff, subcontractors, and

providers take those rights into account when providing services, including the right to:

1) Receive information in accordance with 42 C.F.R. section 438.10. (42 C.F.R. § 438.100(b)(2)(i).)

2) Be treated with respect and with due consideration for their dignity and privacy. (42 C.F.R. § 438.100(b)(2)(ii).)

3) Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. (42 C.F.R. § 438.100(b)(2)(iii).)

4) Participate in decisions regarding their health care, including the right to refuse treatment. (42 C.F.R. § 438.100(b)(2)(iv).)

5) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. (42 C.F.R. § 438.100(b)(2)(v).)

6) Request and receive a copy of their medical records, and to request that they be amended or corrected. (42 C.F.R. § 438.100(b)(2)(vi); 45 C.F.R. §§ 164.524,164.526.)

7) Be furnished services in accordance with 42 C.F.R. §§ sections 438.206 through 438.210. (42 C.F.R. § 438.100(b)(3).)

8) Freely exercise their rights without adversely affecting the way the Contractor, subcontractor, or provider treats the member. (42 C.F.R. § 438.100(c).)

Exhibit A – Attachment 12
MEMBER PROBLEM RESOLUTION

1. General Provisions

A. The Contractor shall have a grievance and appeal system in place for members. (42 C.F.R. §§ 438.228(a), 438.402(a); Cal. Code Regs., tit. 9, § 1850.205.) The grievance and appeal system shall be implemented to handle appeals of adverse benefit determinations and grievances, and shall include processes to collect and track information about them. The Contractor's member problem resolution processes shall include:

1) A grievance process;

2) An appeal process; and,

3) An expedited appeal process. (Cal. Code Regs., tit. 9, § 1850.205(b)(1)-(b)(3).)

B. For the grievance, appeal, and expedited appeal processes, the Contractor shall comply with the following requirements:

1) The Contractor shall ensure that each member has adequate information about the Contractor's problem resolution processes by taking at least the following actions:

a) Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's member booklet and providing the member handbook to members as described in Attachment 11 of this contract. (Cal. Code Regs., tit. 9, § 1850.205(c)(1)(A).)

b) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both members and provider staff. The posted notice shall also explain the availability of State Hearings after the exhaustion of an appeal or expedited appeal process, including information that a State Hearing may be requested whether or not the member has received a notice of adverse benefit determination. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated

by the Contractor or a provider contracting with the Contractor at which members may obtain specialty mental health services. (Cal. Code Regs., tit. 9, §§ 1850.205(c)(1)(B) and 1850.210.)

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

d) Give beneficiaries any reasonable assistance in completing the forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. (42 C.F.R. § 438.406(a); 42 C.F.R. § 438.228(a).)

2) The Contractor shall allow members to file grievances and request appeals. (42 C.F.R. § 438.402(c)(1).) The Contractor shall have only one level of appeal for members. (42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).)

3) A member may request a State Hearing after receiving notice under 438.408 that the adverse benefit determination is upheld. (42 C.F.R. § 438.402(c)(1); 42 C.F.R. § 438.408(f).)

4) The Contractor shall adhere to the notice and timing requirements in §438.408. If the Contractor fails to adhere to these notice and timing requirements, the member is deemed to have exhausted the Contractor's appeals process and may initiate a State Hearing. (42 C.F.R. §§ 438.402(c)(1)(i)(A), 438.408(c)(3).)

5) The Contractor shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the member in writing. (42 C.F.R. § 438.406(b)(1); 42 C.F.R. § 438.228(a); Cal. Code Regs., tit. 9, § 1850.205(d)(4).) Grievances received over the telephone or in-person by the Contractor, or a network provider of the Contractor,

that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment.

6) The Contractor shall allow a provider, or authorized representative, acting on behalf of the member and with the member's written consent to request an appeal, file a grievance, or request a State Hearing. (42 C.F.R. § 438.402(c)(1)(i)-(ii); Cal. Code Regs., tit. 9, § 1850.205(c)(2).)

7) The Contractor shall allow a member's authorized representative to use the grievance, appeal, or expedited appeal processes on the member's behalf. (Cal. Code Regs., tit. 9, § 1850.205(c)(2).)

8) At the member's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a member with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing specialty mental health services to the member requesting assistance, the Contractor shall identify another individual to assist that member. (Cal. Code Regs., tit. 9, § 1850.205(c)(4).) Assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. (42 C.F.R. § 438.406(a).)

9) The Contractor shall not subject a member to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(c)(5).)

10) The Contractor's procedures for the member problem resolution processes shall maintain the confidentiality of each member's information. (Cal. Code Regs., tit. 9, § 1850.205(c)(6).)

11) The Contractor shall include a procedure to transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. The Contractor shall consider these issues

in the Contractor's Quality Improvement Program, as required by Cal. Code Regs., tit. 9, §1810.440(a)(5). (Cal. Code Regs., tit. 9, § 1850.205(c)(7).)

12) The Contractor shall ensure that decision makers on grievances and appeals of adverse benefit determinations were not involved in any previous level of review or decision-making, and were not subordinates of any individual who was involved in a previous level of review or decision-making. (42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a).)

13) The Contractor shall ensure that individuals making decisions on the grievances and appeals of adverse benefit determinations, have the appropriate clinical expertise, as determined by the Department , in treating the member's condition or disease, if the decision involves an appeal based on a denial of medical necessity, a grievance regarding denial of a request for an expedited appeal, or if the grievance or appeal involves clinical issues.(42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).)

14) The Contractor shall provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in section 438.408(b) and (c) in the case of expedited resolution. (42 C.F.R. § 438.406(b)(4).)

15) The Contractor shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the member or member's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a).)

16) The Contractor shall provide the member and their representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied

upon, or generated by the Contractor in connection with the appeal of the adverse benefit determination. (42 C.F.R. § 438.406(b)(5).)

17) The Contractor shall provide the member and their representative the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions, (42 C.F.R. § 438.408(b)-(c).) For standard resolution of an appeal and notice to the affected parties, the Contractor must comply with the Department established timeframe of 30 calendar days from the day the Contractor receives the appeal. For expedited resolution of an appeal and notice to affected parties, the Contractor must comply with the Department established timeframe of 72 hours after the Contractor receives the appeal. (42 C.F.R. § 438.406(b)(5).)

18) The Contractor shall treat oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal) and must confirm these oral inquiries in writing, unless the member or the provider requests expedited resolution. (42 C.F.R. § 438.406(b)(3).)

19) The Contractor's member problem resolution process shall not replace or conflict with the duties of county patient's rights advocates. (W&I Code § 5520.)

2. Handling of Grievances and Appeals

The Contractor shall adhere to the following record keeping, monitoring, and review requirements:

A. Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).) Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6).)

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B. Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the member. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. (Cal. Code Regs., tit. 9, § 1850.205(d)(2).)

C. Provide a staff person or other individual with responsibility to provide information requested by the member or the member's representative regarding the status of the member's grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(3).)

D. Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the **member** . (Cal. Code Regs., tit. 9, § 1850.205(d)(5).)

E. Provide notice, in writing, to any provider identified by the **member** or involved in the grievance, appeal, or expedited appeal of the final disposition of the **member's** ~~'s~~ grievance, appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(6).)

F. Maintain records in the grievance and appeal log accurately and in a manner accessible to the Department and available upon request to CMS. (42 C.F.R. § 438.416(c).)

3. Grievance Process

The Contractor's grievance process shall, at a minimum:

A. Allow **members** ~~beneficiaries~~ to file a grievance either orally, or in writing at any time with the Contractor; (42 C.F.R. § 438.402(c)(2)(i) and (c)(3)(i).)

B. The Contractor shall provide to the member written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the member may contact about the grievance. The written acknowledgement to the member must be postmarked within five calendar days of receipt of the grievance. Grievances received over the telephone or in-person by the Contractor, or a network provider of the

Contractor, that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written notification of resolution using the Written Notification of Grievance Resolution form.

C. Resolve each grievance as expeditiously as the member's health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (42 C.F.R. § 438.408(a)-(b)(1).) The Contractor may extend the timeframe for processing a grievance by up to 14 calendar days if the member requests an extension, or if the Contractor determines, to the satisfaction of DHCS upon request, that there is a need for additional information and that the delay is in the member's interest. (42 C.F.R. § 438.408(c)(1)(i)-(ii).) If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the member, make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice of the extension and the reasons for the extension within 2 calendar days of the decision to extend the timeframe. The Contractor's written notice of extension shall inform the member of the right to file a grievance if they disagree with the Contractor's decision (42 C.F.R. § 438.408(c)(2)(i)-(ii).) The written notice of the extension is not a Notice of Adverse Benefit Determination. (Cal. Code Regs., tit. 9, § 1810.230.5.)

D. The timeframe for resolving grievances related to disputes of a Contractor's decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days.

E. Provide written notification to the member or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the member, if they could not be contacted. (Cal. Code Regs., tit. 9, § 1850.206(c).)

F. Notify the member of the resolution of a grievance in a format and language that meets applicable notification standards. (42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10.)

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MEMBER PROBLEM RESOLUTION

4. Discrimination Grievances

A. For Discrimination Grievances:

1) The Contractor shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. (W&I Code § 14727(a)(4); 45 C.F.R. § 84.7; 34 C.F.R. § 106.8; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B.)

2) The Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. (W&I Code § 14727(a)(4); 45 C.F.R. § 84.7; 34 C.F.R. § 106.8; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B.) The Contractor shall not require a member to file a Discrimination Grievance with the Contractor before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

3) Within ten calendar days of mailing a Discrimination Grievance resolution letter to a member, the Contractor must submit the following information regarding the complaint to the DHCS Office of Civil Rights (see California Medicaid State Plan, § 7, Attachments 7.2-A and 7.2-B):

a) The original complaint.

b) The provider's or other accused party's response to the complaint.

c) Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the Contractor.

d) Contact information for the member filing the complaint, and for the provider or other accused party that is the subject of the complaint.

e) All correspondence with the member regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the member.

f) The results of the Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

5. Appeals Process

A. The Contractor's appeal process shall, at a minimum:

1) Allow a member, or a provider or authorized representative acting on the member's behalf, to file an appeal orally or in writing. (42 C.F.R. § 438.402(c)(3)(ii).) The member may file an appeal within 60 calendar days from the date on the adverse benefit determination notice (42 C.F.R. § 438.402(c)(2)(ii).);

2) Require a member who makes an oral appeal that is not an expedited appeal, to subsequently submit a written, signed appeal. (42 C.F.R. § 438.402(c)(3)(ii).) The Contractor shall ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and confirmed in writing unless the member or the provider requests expedited resolution. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes (42 C.F.R. § 438.406(b)(3).);

3) Resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.408(a); 42 C.F.R. § 438.408(b)(2).) The Contractor may extend the timeframe for processing an appeal by up to 14 calendar days, if the member requests an extension or the Contractor demonstrates, to the satisfaction of DHCS upon request, that there

is a need for additional information and that the delay is in the member's interest. (42 C.F.R. 438.408(c)(1); 42 C.F.R. 438.408(b)(2).) If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the member, make reasonable efforts to give the member prompt oral notice of the delay and notify the member of the extension and the reasons for the extension in writing within 2 calendar days of the decision to extend the timeframe. The Contractor's written notice of extension shall inform the member of the right to file a grievance if they disagree with the Contractor's decision. The Contractor shall resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (42 C.F.R. § 438.408(c)(2)(i)-(iii).) The written notice of the extension is not a Notice of Adverse Benefit Determination. (Cal. Code Regs., tit. 9, §1810.230.5.);

4) Allow the member to have a reasonable opportunity to present evidence and testimony and make arguments of fact or law, in person and in writing (42 C.F.R. § 438.406(b)(4).);

5) Provide the member and their representative the member's case file, including medical records, and any other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor in connection with the appeal of the adverse benefit determination, provided that there is no disclosure of the protected health information of any individual other than the member (42 C.F.R. § 438.406(b)(5).); and

6) Provide the member and their representative the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions. For standard resolution of an appeal and notice to the affected parties, the Contractor must comply with the Department established timeframe of 30 calendar days from the day the Contractor receives the appeal. For expedited resolution of an appeal and notice to affected parties, the Contractor must comply with the Department established timeframe of 72 hours after the Contractor receives the appeal. (42 C.F.R. § 438.406(b)(5).)

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7) Allow the member, their representative, or the legal representative of a deceased member's estate, to be included as parties to the appeal. (42 C.F.R. 438.406(b)(6).)

B. The Contractor shall notify the member, and/or their representative, of the resolution of the appeal in writing in a format and language that, at a minimum, meets applicable notification standards. (42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.408(e); 42 C.F.R. § 438.10.) The notice shall contain the following:

1) The results of the appeal resolution process (42 C.F.R. § 438.408(e)(1).);

2) The date that the appeal decision was made (42 C.F.R. § 438.408(e)(1).);

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

a) Information regarding the member's right to a State Hearing and the procedure for requesting a State Hearing, if the member has not already requested a State Hearing on the issue involved in the appeal; (42 C.F.R. § 438.408(e)(2)(i).) and

b) Information on the member's right to continue to receive benefits while the State Hearing is pending and how to request the continuation of benefits; (42 C.F.R. § 438.408(e)(2)(ii).)

c) Inform the member that they may be liable for the cost of any continued benefits if the Contractor's adverse benefit determination is upheld in the hearing. (42 C.F.R. § 438.408(e)(2)(iii).)

6. Expedited Appeal Process

A. "Expedited Appeal" is an appeal used when the mental health plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's

request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 C.F.R. 438.410.)

B. The Contractor's expedited appeal process shall, at a minimum:

1) Be used when the Contractor determines or the member and/or the member's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 438.410(a).)

2) Allow the member to file the request for an expedited appeal orally without requiring the member to submit a subsequent written, signed appeal. (42 C.F.R. § 438.402(c)(3)(ii).)

3) Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's expedited appeal. (42 C.F.R. § 438.410(b).)

4) Inform members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments for an expedited appeal. The Contractor must inform members of this sufficiently in advance of the resolution timeframe for the expedited appeal. (42 C.F.R. § 438.406(b)(4); 42 C.F.R. § 438.408(b)-(c).)

5) Resolve an expedited appeal and notify the affected parties in writing, as expeditiously as the member's health condition requires and no later than 72 hours after the Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3).) The Contractor may extend this timeframe by up to 14 calendar days if the member requests an extension, or the Contractor demonstrates, to the satisfaction of DHCS upon request, that there is need for additional information and that the delay is in the member's interest. (42 C.F.R. § 438.408(c)(1)(i)-(ii).) If the Contractor extends the timeline for processing an expedited appeal not at the request of the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay and notify the member of the extension and the reasons for the extension, in writing, within 2 calendar days of the determination to extend the timeline. The

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Contractor shall resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. (42 C.F.R. § 438.408(c)(2)(i) - (iii); 42 C.F.R. § 438.408(b)(3).) The written notice of the extension is not a Notice of Adverse Benefit Determination. (Cal. Code Regs., tit. 9, § 1810.230.5.)

6) Provide a member with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the member and/or their representative. The written notice shall meet the requirements of Section 1850.207(h) of Title 9 of the California Code of Regulations. (42 C.F.R. § 438.408(d)(2); Cal. Code Regs., tit. 9, § 1850.207(h).)

7) If the Contractor denies a request for an expedited appeal resolution, the Contractor shall:

   a) Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.410(c)(1).)

   b) Make reasonable efforts to give the member and their representative prompt oral notice of the denial of the request for an expedited appeal. Provide written notice of the decision and reason for the decision within two calendar days of the date of the denial and inform the member of the right to file a grievance if they disagree with the decision. (42 C.F.R. § 438.410(c)(2); 42 C.F.R. § 438.408(c)(2).) The written notice of the denial of the request for an expedited appeal is not a Notice of Adverse Benefit Determination. (Cal. Code Regs., tit. 9, § 1810.230.5.)

7. Contractor obligations related to State Hearing

"State Hearing" means the hearing provided by the State to members pursuant to sections 50951 and 50953 of Title 22 of the California Code of Regulations and section 1810.216.6 of Title 9 of the California Code of Regulations 1810.216.6:

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A. If a member requests a State Hearing, the Department shall grant the request. (42 C.F.R. § 431.220(a)(5).) The right to a State Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member and provider by the Contractor in its notice of decision or Notice of Adverse Benefit Determination. (42 C.F.R. § 431.206(b); 42 C.F.R. § 431.228(b).) Members and providers shall also be informed of the following:

1) A member may request a State Hearing only after receiving notice that the Contractor is upholding the adverse benefit determination. (42 C.F.R. § 438.408(f)(1).)

2) If the Contractor fails to adhere to notice and timing requirements under section 438.408, the member is deemed to have exhausted the Contractor's appeals process, and the member may initiate a State Hearing. (42 C.F.R § 438.408(f)(1)(i); 42 C.F.R. § 438.402(c)(1)(i)(A).)

3) The provider may request a State Hearing only if the Department permits the provider to act as the member's authorized representative. (42 C.F.R. § 438.402(c)(1)(ii).)

8. Expedited Hearing

"Expedited Hearing" means a hearing provided by the State, used when the Contractor determines, or the member or the member's provider certifies that following the 90 day timeframe for a State Hearing as established in 42 C.F.R. section 431.244(f)(1) would seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 431.244(f)(1); 42 C.F.R. § 438.410(a); Cal. Code Regs., tit. 9, § 1810.216.4.)

9. Continuation of Services

A. A member receiving specialty mental health services shall have a right to file for continuation of specialty mental health services pending the outcome of a State Hearing. (Cal. Code Regs., tit. 22., § 51014.2; Cal. Code Regs., tit. 9, § 1850.215.)

B. The Contractor shall continue the member's benefits while an appeal is in process if all of the following occur:

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1) The member files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice; (42 C.F.R. § 438.420(b)(1).)

2) The appeal involves the termination, suspension, or reduction of a previously authorized service; (42 C.F.R. § 438.420(b)(2).)

3) The member's services were ordered by an authorized provider; (42 C.F.R. § 438.420(b)(3).)

4) The period covered by the original authorization has not expired; and, (42 C.F.R. § 438.420(b)(4).)

5) The request for continuation of benefits is filed on or before the later of the following: (42 C.F.R. § 438.420 (b)(5).)

   a. Within 10 calendar days of the Contractor sending the notice of adverse benefit determination; (42 C.F.R. § 438.420(a).); or

   b. The intended effective date of the adverse benefit determination. (42 C.F.R. § 438.420(a).)

C. If, at the member's request, the Contractor continues the member's benefits while the appeal or State Hearing is pending, the benefits must be continued until the member withdraws the appeal or request for State Hearing, the member does not request a State Hearing and continuation of benefits within 10 calendar days from the date the Contractor sends the notice of an adverse appeal resolution, or a State Hearing decision adverse to the member is issued. (42 C.F.R. § 438.420(c)(1)-(3); 42 C.F.R. § 438.408(d)(2).)

D. The Contractor shall not recover the cost of continued services furnished to the member while the appeal or State Hearing was pending if the final resolution of the appeal or State Hearing upholds the Contractor's adverse benefit determination. (42 C.F.R. § 438.420(d); 42 C.F.R. § 431.230(b).)

E. Contractor must automatically continue providing the disputed services to the member while the appeal and State Hearing are pending if all of the

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following conditions are met:

1) The member filed their appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the member's provider; and

4) The period covered by the original authorization has not expired.

F. If Contractor, at the member's request, continues or reinstates the provision of disputed services while an appeal or State Hearing is pending, those services must continue until:

1) The member withdraws their request for an appeal or a State Hearing;

2) The member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or

3) The final State Hearing decision is adverse to the member.

G. Contractor must pay for disputed services if the member received the disputed services while the appeal or State Hearing was pending. Contractor must ensure the member is not billed for the continued services even if the State Hearing finds the disputed services were not medically necessary.

H. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination if the services were not furnished while the appeal was pending and if the Contractor or State Hearing officer reverses a decision to deny, limit, or delay services. (42 C.F.R. § 438.424(a).)

I. If the decision of an appeal reverses a decision to deny the authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall cover the cost of such services. (42 C.F.R. § 438.424(b).)

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J. The Contractor shall notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 C.F.R. § 438.210(c); 42 C.F.R. § 438.404.)

10. Provision of Notice of Adverse Benefit Determination

A. The Contractor shall provide a member with a Notice of Adverse Benefit Determination (NOABD) under the following circumstances:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (42 C.F.R. § 438.400(b)(1).)

2) The reduction, suspension, or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2).)

3) The denial, in whole or in part, of payment for a service. (42 C.F.R. § 438.400(b)(3).)

4) The failure to provide services in a timely manner, as defined by the Department. (42 C.F.R. § 438.400(b)(4).)

5) The failure of the Contractor to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 C.F.R. § 438.400(b)(5).)

6) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. (42 C.F.R. § 438.400(b)(7).)

B. The Contractor shall give members timely and adequate notice of an adverse benefit determination in writing and shall meet the language and format requirements of 42 Code of Federal Regulations section 438.10. (42 C.F.R. § 438.404(a); 42 C.F.R. § 438.10.) The NOABD shall contain the items specified in 42 Code of Federal Regulations part 438.404 (b) and Cal. Code Regs., tit. 9, section 1850.212.

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C. When the denial or modification involves a request from a provider for continued Contractor payment authorization of a specialty mental health service or when the Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with Cal. Code Regs., tit. 22, section 51014.1. (Cal. Code Regs., tit. 9, § 1850.210(a)(1).)

D. A NOABD is not required when a denial is a non-binding verbal description to a provider of the specialty mental health services that may be approved by the Contractor. (Cal. Code Regs., tit. 9, § 1850.210(a)(2).)

E. Except as provided in subsection F below, a NOABD is not required when the denial or modification is a denial or modification of a request for the Contractor payment authorization for a specialty mental health service that has already been provided to the member. (Cal. Code Regs., tit. 9, § 1850.210(a)(4).)

F. A NOABD is required when the Contractor denies or modifies a payment authorization request from a provider for a specialty mental health service that has already been provided to the member when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor. (Cal. Code Regs., tit. 9, § 1850.210(b).)

G. The Contractor shall deny the Contractor payment authorization request and provide the member with a NOABD when the Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by Cal. Code Regs., tit. 9, sections 1820.220 or 1830.215. (Cal. Code Regs., tit. 9, § 1850.210(c).)

H. The Contractor shall provide the member with a NOABD if the Contractor fails to notify the affected parties of a resolution of a grievance within 90 calendar days, of an appeal decision within 30 days, or of an expedited appeal decision within 72 hours. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to sections 1850.206, 1850.207 or 1850.208 of Title 9 of the California Code of Regulations and the Contractor failed to notify the affected parties of its decision within the

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extension period, the Contractor shall provide the member with a NOABD. (42 C.F.R. § 438.408.)

I. The Contractor shall provide a member with a NOABD when the Contractor or its providers determine that the criteria for access to SMHS in Attachment 2, section 1 have not been met and that the member is not entitled to any specialty mental health services from the Contractor. The NOABD shall, at the election of the Contractor, be hand-delivered to the member on the date of the Adverse Benefit Determination or mailed to the member in accordance with Cal. Code Regs., tit. 9, section 1850.210(f)(1), and shall specify the information contained in Cal. Code Regs., tit. 9, section 1850.212(b). (Cal. Code Regs., tit. 9, § 1850.210(g).)

J. For the purpose of this Attachment, each reference to a Medi-Cal managed care plan in Cal. Code Regs., tit. 22, section 51014.1, shall mean the Contractor. (Cal. Code Regs., tit. 9, § 1850.210(h).)

K. For the purposes of this Attachment, “medical service”, as used in Cal. Code Regs., tit. 22, section 51014.1, shall mean specialty mental health services that are subject to prior authorization by a Contractor pursuant to Cal. Code Regs., tit. 9, sections 1820.100 and 1830.100. (Cal. Code Regs., tit. 9, § 1850.210(i).)

L. The Contractor shall retain copies of all Notices of Adverse Benefit Determination issued to beneficiaries under this Section in a centralized file accessible to the Department. The Department shall engage in random reviews (Cal. Code Regs., tit. 9, § 1850.210(j).)

M. The Contractor shall allow the State to engage in reviews of the Contractor’s records pertaining to Notices of Adverse Benefit Determination so the Department may ensure that the Contractor is notifying members in a timely manner.

11. Contents and Timing of NOABD

A. The Contractor shall include the following information in the NOABD:

1) The adverse benefit determination the Contractor has made or intends to make. (42 C.F.R. § 438.404(b)(1).)

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2) The reason for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes criteria to access SMHS, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2).)

3) Citations to the regulations or Contractor payment authorization procedures supporting the adverse benefit determination. (Cal. Code Regs., tit. 9, § 1850.212(a)(3).)

4) The member's right to file, and procedures for exercising, an appeal or expedited appeal with the Contractor, including information about exhausting the Contractor's one level of appeal and the right to request a State Hearing after receiving notice that the adverse benefit determination is upheld. (42 C.F.R. § 438.404(b)(3)-(b)(4).)

5) The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5).)

6) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and that the member shall not be held liable for the cost of the benefits if the hearing decision upholds the Contractor's adverse benefit determination.

7) Information about the member's right to request a State Hearing or an expedited State Hearing, including:

   a) The method by which a hearing may be obtained; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(A).)

   b) A statement that the member may be either self-represented or represented by an authorized third party such as legal counsel, a relative, friend, or any other person; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(B).)

   c) An explanation of the circumstances under which a specialty mental health service will be continued if a State Hearing is

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requested; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(C).) and

d) The time limits for requesting a State Hearing or an expedited State Hearing. (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(D).)

B. The Contractor shall mail the NOABD within the following timeframes:

1) For termination, suspension, or reduction of previously authorized Medi-Cal covered services, at least 10 days before the date of action. (42 C.F.R. § 438.404(c)(1); 42 C.F.R. § 431.211.) The Contractor shall mail the NOABD in as few as 5 days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the member, and the facts have been verified, if possible, through secondary sources. (42 C.F.R. § 438.404(c)(1); 42 C.F.R. §.431.214.)

2) For denial of payment, at the time of any action affecting the claim. (42 C.F.R. § 438.404(c)(2).)

3) For standard service authorizations that deny or limit services, as expeditiously as the member's condition requires not to exceed 14 calendar days following the receipt for request for services. (42 C.F.R. § 438.404(c)(3); 42 C.F.R. 438.210(d)(1).)

4) The Contractor may extend the 14 calendar day NOABD determination timeframe for standard service authorization decisions that deny or limit services up to 14 additional calendar days if the member or the provider requests the extension. (42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 438.210(d)(1)(i).)

5) The Contractor may extend the 14 calendar day notice of adverse benefit determination timeframe for standard service authorization decisions that deny or limit services up to 14 additional calendar days if the Contractor justifies a need to the Department, upon request, for additional information and shows how the extension is in the member's best interest. (42 C.F.R. § 438.404(c)(4); 42 C.F.R. § 438.210(d)(1)(ii).)

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6) If the Contractor extends the 14 calendar day notice of adverse benefit determination timeframe for standard service authorization decisions that deny or limit services, the Contractor shall do the following:

   a) Give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he/she disagrees with the decision; (42 C.F.R. § 438.404(c)(4)(i); 42 C.F.R. § 438.210(d)(1)(ii).) and,

   b) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date of the extension. (42 C.F.R. § 438.404(c)(4)(ii); 42 C.F.R. § 438.210(d)(1)(ii).)

7) The Contractor shall give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations. (42 C.F.R. § 438.404(c)(5).)

8) If a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or their ability to attain, maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. § 438.210(d)(2)(i).)

9) The Contractor may extend the 72-hour expedited service authorization decision time period by up to 14 calendar days if the member requests an extension, or if the Contractor justifies to the Department, upon request, a need for additional information and how the extension is in the member's interest. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. § 210(d)(2)(ii).)

10) The Contractor shall deposit the NOABD with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires. (Cal. Code Regs., tit. 9, § 1850.210(f).)

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C. The Adverse Benefit Determination shall be effective on the date of the NOABD, and the Contractor shall mail the NOABD by the date of adverse benefit determination when any of the following occur:

1) The death of a member; (42 C.F.R. § 431.213(a).)

2) Receipt of a signed written member statement requesting service termination or giving information requiring termination or reduction of services, provided the member understands that this will be the result of supplying that information; (42 C.F.R. § 431.213(b)(1)-(b)(2).)

3) The member's admission to an institution where they are ineligible for further services; (42 C.F.R. § 431.213(c).)

4) The member's whereabouts are unknown and mail directed to them has no forwarding address; (42 C.F.R. § 431.213(d).)

5) Notice that the member has been accepted for Medicaid services by another local jurisdiction; (42 C.F.R. § 431.213(e).)

6) A change in the member's physician's prescription for the level of medical care; (42 C.F.R. § 431.213(f).) or

7) The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act. (42 C.F.R. § 431.213(g).)

8) The transfer or discharge from a facility will occur in an expedited fashion. (42 C.F.R. § 431.213(h).)

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

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12. Annual Grievance and Appeal Report

The Contractor is required to submit to the Department a report that summarizes member grievances, appeals and expedited appeals, in accordance with BHIN 22-036, filed from July 1 of the previous year through June 30 of that year by September 1 of each year. The report shall include the total number of grievances, appeals, and expedited appeals by type, by subject areas established by the Department, and by disposition. (42 C.F.R. § 438.66(e)

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PROGRAM INTEGRITY

1. General Requirements

As a condition for receiving payment under a Medi-Cal managed care program, the Contractor shall comply with the provisions of 42 C.F.R. sections 438.604, 438.606 and 438.608, and 438.610. (42 C.F.R. § 438.600(b).)

2. Periodic Audits

Contractor shall be subject to an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the Contractor. The audit shall occur no less frequently than once every three year. Commencing Fiscal Year 2023/2024, Contractor shall comply with BHIN 23-044 and any superseding departmental guidance. The Department or its contractor shall conduct the audit. (42 C.F.R. § 438.602, subd. (e).)

3. Excluded Providers

A. The Contractor shall screen and periodically revalidate all network providers in accordance with the requirements of 42 Code of Federal Regulations, section 455, subparts B and E. (42 C.F.R. §438.602(b).)

B. Consistent with the requirements of 42 Code of Federal Regulations, section 455.436, the Contractor must confirm the identity and determine the exclusion status of all providers (employees and network providers) and any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the of the Mental Health Plan through routine checks of Federal and State databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), as well as the Department's Medi Cal Suspended and Ineligible Provider List (S & I List). (42 C.F.R. §438.602(d).)

C. If the Contractor finds a party that is excluded, it must promptly notify the Department (42 C.F.R. §438.608(a)(2),(4)) and the Department will take action consistent with 42 C.F.R. section 438.610((d). The Contractor shall not certify or pay any excluded provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

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4. Compliance Program

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

B. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain a compliance program designed to detect and prevent fraud, waste and abuse that must include:

1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.

2) A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the CEO and the Board of Directors (BoD).

3) A Regulatory Compliance Committee (RCC) on the BoD and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

4) A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.

5) Effective lines of communication between the CO and the organization's employees.

6) Enforcement of standards through well-publicized disciplinary guidelines.

7) The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they

are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract. (42 C.F.R. § 438.608(a), (a)(1).)

5. Fraud Reporting Requirements

A. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to the Department about the following:

1) Any potential fraud, waste, or abuse. (42 C.F.R. § 438.608(a), (a)(7).)

2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. § 438.608(a), (a)(2).)

3) Information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or the death of the member. (42 C.F.R. § 438.608(a), (a)(3).)

4) Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. (42 C.F.R. § 438.608(a), (a)(4).)

B. If the Contractor identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying the Department, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

Exhibit A – Attachment 13
PROGRAM INTEGRITY

C. The Contractor shall implement and maintain written policies for all employees of the Mental Health Plan, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and state laws, including information about rights of employees to be protected as whistleblowers. (42 C.F.R. § 438.608(a), (a)(6).)

D. The Contractor shall implement and maintain arrangements or procedures that include provision for the Contractor's suspension of payments to a network provider for which there is a credible allegation of fraud. (42 C.F.R. § 438.608(a), (a)(8).)

6. Service Verification

Pursuant to 42 C.F.R. section 438.608(a)(5), the Contractor, and/or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. (42 C.F.R. § 438.608(a), (a)(5).)

7. Disclosures

A. Disclosure of 5% or More Ownership Interest:

1) Pursuant to 42 C.F.R. section 455.104, Medicaid managed care entities must disclose certain information related to persons who have an ownership or control interest in the managed care entity, as defined in 42 C.F.R. section 455.101. The parties hereby acknowledge that because the Contractor is a political subdivision of the State of California, there are no persons who meet such definition and therefore there is no information to disclose.

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

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PROGRAM INTEGRITY

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

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

2) The Contractor shall ensure that its subcontractors and network providers submit the disclosures below to the Contractor regarding the network providers' (disclosing entities') ownership and control. The Contractor's network providers must be required to submit updated disclosures to the Contractor upon submitting the provider application, before entering into or renewing the network providers' contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 Code of Federal Regulations section 455.104.

a) Disclosures to be Provided:

i. The name and address of any person (individual or corporation) with an ownership or control interest in the network provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;
ii. Date of birth and Social Security Number (in the case of an individual);
iii. Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);
iv. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or

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

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

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

3) For each provider in Contractor's provider network, the Contractor shall provide the Department with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from the Department during the re-validation of enrollment process under 42 Code of Federal Regulations section 455.104.

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

1) The following information must be disclosed:

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

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

Exhibit A – Attachment 13
PROGRAM INTEGRITY

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

C. Disclosures Related to Persons Convicted of Crimes

1) The Contractor shall submit the following disclosures to the Department regarding the Contractor's management:

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

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

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

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

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

1. Data Submission/ Certification Requirements

A. The Contractor shall submit any data, documentation, or information relating to the performance of the entity's obligations as required by the State or the United States Secretary of Health and Human Services. (42 C.F.R. § 438.604(b).) The individual who submits this data to the state shall concurrently provide a certification, which attests, based on best information, knowledge and belief that the data, documentation and information is accurate, complete and truthful. (42 C.F.R. § 438.606(b) and (c).) The data, documentation, or information submitted to the state by the Contractor shall be certified by one of the following:

1) The Contractor's Chief Executive Officer (CEO).

2) The Contractor's Chief Financial Officer (CFO).

3) An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. (42 C.F. R. § 438.606(a).)

2. Encounter Data

The Contractor shall submit encounter data to the Department at a frequency and level specified by the Department and CMS. (42 C.F.R. § 438.242(c)(2).) The Contractor shall ensure collection and maintenance of sufficient member encounter data to identify the provider who delivers service(s) to the member. (42 C.F.R. § 438.242(c)(1).) The Contractor shall submit all member encounter data that the Department is required to report to CMS under section 438.818. (42 C.F.R. § 438.242(c)(3).) The Contractor shall submit encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. (42 C.F.R. § 438.242(c)(4).)

3. Insolvency

A. The Contractor shall submit data to demonstrate it has made adequate provision against the risk of insolvency to ensure that members will not be liable for the Contractor's debt if the Contractor becomes insolvent. (42 C.F.R. § 438.604(a)(4); 42 C.F.R. § 438.116.)

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

B. The Contractor shall meet the State's solvency standards for private health maintenance organizations or be licensed by the State as a risk-bearing entity, unless one of the following exceptions apply (42 C.F.R. § 438.116 (b).):

1) The Contractor does not provide both inpatient hospital services and physician services.

2) The Contractor is a public entity.

3) The Contractor is (or is controlled by) one of more federally qualified health centers and meets the solvency standards established by the State for those centers.

4) The Contractor has its solvency guaranteed by the State.

4. Network Adequacy

The Contractor shall submit, in a manner and format determined by the Department, documentation to demonstrate compliance with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network. (42 C.F.R. § 438.604(a)(5).)

5. Information on Ownership and Control

The Contractor shall submit for state review information on its and its subcontractors' ownership and control described in 42 C.F.R. section 455.104 and Attachment 13 of this Contract. (42 C.F.R § 438.604(a)(6).)

6. Annual Report of Overpayment Recoveries

The Contractor shall submit an annual report of overpayment recoveries in a manner and format determined by the Department. (42 C.F.R § 438.604(a)(7).)

7. Performance Data

A. In an effort to improve the performance of the State's managed care program, in accordance with 42 Code of Federal Regulations section 438.66(c), the Contractor will submit the following to the Department (42 C.F.R. § 438.604(b).):

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

1) Enrollment and disenrollment data;

2) Member grievance and appeal logs;

3) Provider complaint and appeal logs;

4) The results of any member satisfaction survey;

5) The results of any provider satisfaction survey;

6) Performance on required quality measures;

7) Medical management committee reports and minutes;

8) The Contractor's annual quality improvement plan;

9) Audited financial and encounter data; and

10) Customer service performance data.

B. The Contractor shall cooperate with DHCS to provide and report quality measures per the 1915(b) Special Terms and Conditions and the Comprehensive Quality Strategy.

8. Parity in Mental Health and Substance Use Disorder Services

The Contractor shall submit to the Department, upon request, any policies and procedures or other documentation necessary for the State to establish and demonstrate compliance with Title 42 of the Code of Federal Regulations, part 438, subpart K, regarding parity in mental health and substance use disorder benefits.

Exhibit A – Attachment 15
PEER SUPPORT SERVICES

MEDI-CAL PEER SUPPORT SERVICES

1. The Contractor has taken the option to implement Medi-Cal Peer Support Services.

2. The Contractor shall provide, or arrange, and pay for Peer Support Services to Medi-Cal members. Contractor's provision of Peer Support Services shall conform to the requirements of Supplement 3 to Attachment 3.1-A and Supplement 3 to Attachment 3.1-B of the California State Plan. Contractor's provision of Peer Support Services and implementation of a Medi-Cal Peer Support Specialist Certification Program shall further conform to the applicable requirements of Behavioral Health Information Notice (BHIN) 21-041 and to the requirements in any subsequent BHINs issued by the Department pursuant to W&I Code section 14045.21.

3. Voluntary Participation and Funding

   The Contractor shall fund the nonfederal share of any applicable expenditures, since the Contractor has opted to implement Peer Support Services and participate in the Peer Support Specialist Certification Program set forth in Article 1.4 of Chapter 7, Part 3, of Division 9 of the Welfare and Institutions Code. The Contractor’s local share utilized to fund Peer Support Services and the Contractor’s participation in the Peer Support Specialist Certification Program shall not be considered an increase in costs mandated by the 2011 realignment legislation.

4. Provision of Peer Support Services

   Peer Support Services may be provided face-to-face, by telephone or by telehealth with the member or significant support person(s) and may be provided anywhere in the community.

5. Peer Support Specialists

   Contractor shall ensure that Peer Support Services are provided by certified Peer Support Specialists as established in BHIN 21-041.

6. Behavioral Health Professional and Peer Support Specialist Supervisors

Exhibit A – Attachment 15
PEER SUPPORT SERVICES

The Contractor shall ensure that Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of SMHS, DMC-ODS, or DMC.

Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041.

7. Practice Guidelines

   Counties shall require Peer Support Specialists to adhere to the practice guidelines developed by the Substance Abuse and Mental Health Services Administration, *What are Peer Recovery Support Services* (Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No.(SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), which may be accessed electronically through the following Internet World Wide Web connection: www.samhsa.gov/resource/ebp/what-are-peer-recovery-support-services.

8. Contractor shall oversee and enforce the certification standards and requirements set forth in Article 1.4 of Chapter 7, Part 3, of Division 9 of the Welfare and Institutions Code and departmental guidance, including BHIN 21-041. Contractor shall ensure that the Medi-Cal Peer Support Specialist Certification Program:

   a. Submits to the department a peer support specialist program plan in accordance with Enclosure 2 of BHIN 21-041 describing how the peer support specialist program will meet all of the federal and state requirements for the certification and oversight of peer support specialists.

   b. Participates in periodic reviews conducted by the department to ensure adherence to all federal and state requirements.

   c. Submits annual peer support specialist program reports to the department in accordance with Enclosure 5 of BHIN 21-041. Reports shall cover the fiscal year and shall be submitted by the following December 31st.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

1. Medical Assistance Payment Provisions

The Department will reimburse the Contractor for Specialty Mental Health Services provided pursuant to the requirements in Exhibit A to this contract, based upon a fee schedule developed by the Department and specified in the approved Medicaid State plan and waivers.

2. Budget Contingency Clause

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

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

B. Delayed Federal Funding

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

3. Federal Financial Participation

Nothing in this contract shall limit the Contractor's ability to submit claims for appropriate FFP reimbursement for any covered services, quality assurance and utilization review, Medi-Cal Administrative Activities and/or administrative costs. In accordance with the Contractor shall ensure compliance with all requirements necessary for Medi-Cal reimbursement for these services and activities, including the requirements in Welfare & Institutions (W&I) Code, section 14184.403. Claims for FFP reimbursement shall be submitted by the Contractor to the Department for adjudication throughout the fiscal year.

4. Audits and Recovery of Overpayments

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

A. Pursuant to Welf. & Inst. Code section 14707, in the case of federal audit exceptions, the Department will follow federal audit appeal processes unless the Department, in consultation with the County Behavioral Health Director's Association of California, determines that those appeals are not cost beneficial.

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

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

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

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

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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

the maximum amount when necessary for compliance with federal laws and regulations.

C. Pursuant to the W&I Code section 14170 and 42 C.F.R. section 438.602, data submitted to the Department are subject to audit in the manner and form prescribed by the Department. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. In accordance with the W&I Code § 14170, any audit of Contractor's data shall occur within three years of the date of receipt by the Department with signed certification by the Contractor's Mental Health Director or an individual who has delegated authority to sign for and reports directly to the Contractor's Mental Health Director. A signature is required before the data shall be considered final. For purposes of this section, the data shall be considered audited once the Department has informed the Contractor of its intent to make adjustments, or once the Department has informed the Contractor of its intent to close the audit.

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

5. Claims Adjudication Process

A. Pursuant to W&I Code section 14184.403, claims for Medicaid reimbursement shall comply with eligibility and service requirements under applicable federal and state law.

B. The Contractor shall certify each claim submitted to the Department in accordance with Cal. Code Regs., tit. 9, section 1840.112 and 42 C.F.R. section 433.51, at the time the claims are submitted to the Department. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification, declaring, under penalty of perjury that, to the best of their knowledge and belief, the claim is in all respects true, correct, and in accordance with the law and meets the requirements of Cal. Code Regs., tit. 9, section 1840.112(b) and 42 C.F.R. sections 438.604 and 438.606. 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 member. If the

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 C.F.R. section 438.604.

C. The Contractor shall certify that any funds transferred to the Department by the Contractor qualify for federal financial participation pursuant to 42 CFR section 433.51, any other applicable federal Medicaid laws, and the CalAIM Special Terms and Conditions, and are not derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include revenue relating to patient care or other revenue received from federal health care programs to the extent that the program revenue is not obligated to the State as the source of funding.

The Contractor shall certify each claim submitted to the Department in accordance with 9 California Code of Regulations (CCR), section 1840.112 and 42 CFR sections 438.604, 438.606 and 438.608. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification, declaring under penalty of perjury that, to the best of their knowledge and belief, the claim in all respects is true, correct, and in accordance with the law and meets the requirements of 9 CCR section 1840.112 and 42 CFR sections 438.604 and 438.606. 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 member. If the Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 CFR, section 438.604.

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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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

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

6. Payment Data Certification

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

7. System Changes

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

8. Administrative Reimbursement

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

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

B. Administrative costs shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medical Assistance Program Cost Allocation and shall be limited to 15 percent of the total actual payments for direct client services. The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative costs.

9. Notification of Request for Contract Amendment

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

Exhibit E
ADDITIONAL PROVISIONS

1. Amendment Process

Should either party, during the term of this Contract, desire a change or amendment to the terms of this Contract, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

2. Cancellation/Termination

A. General Provisions

1) As required by, if the Contractor decides not to contract with the Department, does not renew its contract, or is unable to meet the standards set by the Department, the Contractor agrees to inform the Department of this decision in writing. (W&I Code § 14712(c)(1).)

2) If the Contractor is unwilling to contract for the delivery of specialty mental health services or if the Department or Contractor determines that the Contractor is unable to adequately provide specialty mental health services or that the Contractor does not meet the standards the Department deems necessary for a mental health plan, the Department shall ensure that specialty mental health services are provided to Medi-Cal members. (W&I Code § 147122(c)(2), (3).)

3) The Department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the Department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the Department. The Contractor may not subsequently contract to provide specialty mental health services unless the Department elects to contract with the Contractor. (W&I Code § 147122(c)(4).)

Exhibit E
ADDITIONAL PROVISIONS

4) If the Contractor does not contract with the Department to provide specialty mental health services, the Department will work with the Department of Finance and the Controller to obtain funds from the Contractor in accordance with Government (Govt.) Code 30027.10. (W&I Code § 147122(d).)

A. Contract Renewal

1) This contract may be renewed if the Contractor continues to meet the requirements of Chapter 8.9 of Part 3 of Division 9 of the W&I Code and implementing regulatory requirements, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. (42 C.F.R. § 438.708; W&I Code § 14714(b)(1).) The Department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract. (W&I Code § 14714(b)(1).)

2) In the event the contract is not renewed based on the reasons specified in (1), the Department will notify the Department of Finance, the fiscal and policy committees of the Legislature, and the Controller of the amounts to be sequestered from the Mental Health Subaccount, the Mental Health Equity Account, and the Vehicle License Fee Collection Account of the Local Revenue Fund and the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and the Controller will sequester those funds in the Behavioral Health Subaccount pursuant to Govt. Code § 30027.10. Upon this sequestration, the Department will use the funds in accordance with Govt. Code § 30027.10. (W&I Code § 14714(b)(2).)

B. Contract Amendment Negotiations

Should either party during the life of this contract desire a change in this contract, such change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal in writing within 10 days and shall have 60 days (or such different period as the parties mutually may set) 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 the 60-day period and shall be confirmed in writing within five days

Exhibit E
ADDITIONAL PROVISIONS

thereafter. The party proposing any such change shall have the right to withdraw the proposal at 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 costs 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 Termination

The Contractor may terminate this contract in accordance with, Cal. Code Regs., tit. 9, section 1810.323(a). The Department may terminate this contract in accordance with W&I Code, sections 14197.7, 14714 and Cal. Code Regs., tit. 9, section 1810.323.

1) DHCS shall terminate this contract if the United States Secretary of Health and Human Services has determined the Contractor does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code. (W&I Code § 14197.7(i))

2) DHCS reserves the right to cancel or terminate this Contract if DHCS finds that Contractor fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. (W&I Code § 14197.7(a))

3) Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor report to the department. (W&I Code § 14197.7(a))

4) Contract termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor, unless Contractor appeals the termination, or termination is immediate pursuant to

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paragraph 8. The notice shall identify any final performance, invoicing or payment requirements.

5) Contractor may appeal contract termination pursuant to W&I Code sections 14197.7(I)(2) or section 14714(d).

6) Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel, or if cancelation is not possible reduce, subsequent contract costs.

7) In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Contract and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.

8) The Department will immediately terminate this Contract if the Department finds that there is an immediate threat to the health and safety of Medi-Cal members. Termination of the contract for other reasons will be subject to reasonable notice to the Contractor of the Department's intent to terminate, as well as notification to affected members. (W&I Code § 14714(d).)

D. Termination of Obligations

1) 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 members 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 members prior to such expiration or termination.

2) When the Contractor terminates a subcontract with a provider, the Contractor shall make a good faith effort to provide notice of this termination, within 15 days, to the persons that the Contractor, based on available information, determines have recently been receiving services from that provider.

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E. 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, California Code of Regulations, title 9, or the processes governing the audit appeals process in Chapter 9 of Division 1, California Code of Regulations, title 9 the Contractor shall follow the Dispute Resolution Process outlined in provision number 15 of Exhibit D(F) which is attached hereto as part of this contract.

3. Fulfillment of Obligation

No covenant, condition, duty, obligation, or undertaking continued or made a part of this contract shall 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. 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.

4. Additional Provisions

A. Inspection Rights/Record Keeping Requirements

1) Provision number seven (Audit and Record Retention) of Exhibit D(F), which is attached hereto as part of this Contract, supplements the following requirements.

2) The Contractor, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. The Contractor shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years

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from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, member records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for members.

3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to the Contractor's or subcontractor's performance under this Contract, including member grievance and appeal records identified in Attachment 12, Section 2 and the data, information and documentation specified in 42 Code of Federal Regulations parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (42 C.F.R. § 438.3(u); See also § 438.3(h).) Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to the Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, member records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for members.

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B. Notices

Unless otherwise specified in this contract, 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:

Department of Health Care Services Medi-Cal Behavioral Health Division 1501 Capitol Avenue, MS 2702 Sacramento, CA 95814	[Contractor Name] [Contractor Address]

C. Nondiscrimination

1) Consistent with the requirements of applicable federal law, such as 42 Code of Federal Regulations, part 438.3(d)(3) and (4), and state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of members, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect any ground protected under federal or state law, including sex, race, color, gender, gender identity, religion, marital status, national origin, ethnic group identification, ancestry, age, sexual orientation, medical condition, genetic information, or mental or physical handicap or disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(3-4); 45 C.F.R. § 92.2; Gov. Code § 11135(a); W&I Code § 14727(a)(3).)

2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), prohibiting exclusion, denial of benefits, and discrimination against qualified individuals with a disability in any federally assisted programs or activities, and shall comply with the implementing regulations in Parts 84 and 85 of Title 45 of the C.F.R., as applicable.

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

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D. 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 contract shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this contract. Nothing herein contained shall 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 and its agents and employees shall not be entitled to any rights or privileges of the Contractor's employees and shall not be considered in any manner to be Contractor employees. The Contractor and 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.

E. Waiver of Default

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

5. Duties of the State

In discharging its obligations under this contract, and in addition to the obligations set forth in other parts of this contract, the Department shall perform the following duties:

A. Payment for Services

The Department shall make the appropriate payments set forth in Exhibit B and take all available steps to secure and pay FFP to the Contractor, once the Department receives FFP, for claims submitted by the Contractor. The Department shall notify Contractor and allow Contractor an opportunity to comment to the Department when questions are posed by CMS, or when there is a federal deferral, withholding, or disallowance with respect to claims made by the Contractor.

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B. Reviews

The Department shall conduct reviews of access to and quality of care in the Contractor's county at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, pursuant to Cal. Code Regs., tit. 9, section 1810.380, subdivision (a), and W&I Code § 14197.7. The Department shall also arrange for an annual external quality review of the Contractor as required by 42 Code of Federal Regulations, part 438.350 and Cal. Code Regs., tit. 9, section 1810.380(a)(7).

C. Monitoring for Compliance

When monitoring activities identify areas of non-compliance, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action. Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to W&I Code § 14197.7.

D. The Contractor shall prepare and submit a report to the Department that provides information for the areas set forth in 42 C.F.R. § 438.66(b) and (c) as outlined in Exhibit A, Attachment 14, Section 7, in the manner specified by the Department.

E. If the Contractor has not previously implemented a Mental Health Plan or Contractor will provide or arrange for the provision of covered benefits to new eligibility groups, then the Contractor shall develop an Implementation Plan (as defined in Cal. Code Regs., tit. 9, § 1810.221) that is consistent with the readiness review requirements set forth in 42 Code of Federal Regulations, part 438.66(d)(4), and the requirements of Cal. Code Regs., tit. 9, § 1810.310 (a). (See 42 C.F.R. § 438.66(d)(1), (4).) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to the Contractor within 60 days of the receipt of the Implementation Plan. (Cal. Code Regs., tit. 9, § 1810.310(b).) A Contractor shall submit proposed changes to its approved Implementation Plan in writing to the Department for review. A Contractor shall submit proposed changes in the policies, processes or procedures that would modify the Contractor's current Implementation Plan prior to implementing the proposed changes.(See Cal. Code Regs., tit. 9, § 1810.310 (b)-(c)).

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F. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Cal. Code Regs., tit. 9, § 1810.410. 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 receipt of the plan from the Contractor. If the Department fails to provide a Notice of Approval or Disapproval, the Contractor may implement the plan 60 calendar days from its submission to the Department.

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

1) The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with Cal. Code Regs., tit. 9, section 1810.435, and the requirements specified in Exhibit A, Attachment 8, Section 8 of this contract. This certification shall be performed 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 Cal. Code Regs., tit. 9, § 1810.435(e), shall be conducted of any site owned, leased, or operated by the Contractor and used for to deliver covered services to members, except that on-site review is not required for public school or satellite sites.

2) The Department may allow the Contractor to begin delivering covered services to members 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 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, whichever date is latest.

3) The Department may allow the Contractor to continue delivering covered services to members 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 all required fire clearances.

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4) 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 FFP by the Contractor and the Department's tracking of that information.

H. Excluded Providers

1) If the Department learns that the Contractor has a prohibited affiliation, as described in Attachment 1, Section 2, the Department:

a) Must notify the Secretary of the noncompliance.

b) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

c) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

d) Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act. (42 C.F.R. §438.610(d).)

I. Sanctions

The Department shall conduct oversight in accordance with Cal. Code Regs., tit. 9, §§ 1810.380(a) and impose sanctions on the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations, or the state plan or approved waivers, or for other good cause in accordance with W&I Code § 14197.7 and guidance issued by the Department pursuant to subdivision (r) of W&I Code § 14197.7.

J. Notification

The Department shall notify members of their Medi-Cal specialty mental health benefits and options available upon termination or expiration of this contract.

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K. Performance Measurement

The Department shall measure the Contractor's performance based on Medi-Cal approved claims and other data submitted by the Contractor to the Department using standard measures established by the Department in consultation with stakeholders.

6. State and Federal Law Governing this Contract

A. The Contractor/Subrecipient Designation: the Contractor is considered a contractor subject to 2 C.F.R Part 200 (45 C.F.R. Part 75).

B. The Contractor agrees to comply with all applicable federal and state law, including but not limited to the statutes and regulations incorporated by reference below in Sections D, G, and H, and applicable sections of the State Plan, applicable federal waivers, and applicable Behavioral Health Information Notices (BHINs) in its provision of services as the Mental Health Plan. The Contractor agrees to comply with any changes to these statutes, and regulations, State Plan, federal waivers, and BHINs that occur during the contract period. The Contractor shall also comply with any newly applicable statutes, regulations, State Plan Amendments, federal waivers, and BHINs that become effective during the contract period. These obligations shall apply without the need for a Contract amendment(s). To the extent there is a conflict between the terms of this Contract and any federal or state statute or regulation, the State Plan, federal waivers, or BHIN, the Contractor shall comply with the federal or state statute or regulation, the State Plan, federal waiver, or BHIN and the conflicting Contract provision shall no longer be in effect.

C. The Contractor agrees to comply with all existing policy letters issued by the Department. All policy letters issued by the Department subsequent to the effective date of this Contract shall provide clarification of the Contractor’s obligations pursuant to this Contract and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to State or federal statutes or regulations, or pursuant to judicial interpretation.

D. Federal Laws Governing this Contract:

1) Title 42 United States Code, to the extent that these requirements are applicable;

2) 42 C.F.R. to the extent that these requirements are applicable;

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3) 42 C.F.R. Part 438, Medicaid Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHPs), except for the provisions listed in paragraph D and E, below.

4) 42 C.F.R. § 455 to the extent that these requirements are applicable;

5) 45 C.F.R. § 92.1 et seq. to the extent these requirements are applicable;

6) Title VI of the Civil Rights Act of 1964;

7) Title IX of the Education Amendments of 1972;

8) Age Discrimination Act of 1975;

9) Rehabilitation Act of 1973;

10) Americans with Disabilities Act;

11) Section 1557 of the Patient Protection and Affordable Care Act;

12) Deficit Reduction Act of 2005;

13) Balanced Budget Act of 1997;

14) The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act, 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.

15) The Contractor shall comply with the provisions of the Davis-Bacon Act, as amended, which provides 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 as supplemented by Department of Labor regulations.

16) The Contractor shall comply with the provisions of the Contract Work Hours and Safety Standards Act, as applicable, which

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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 the Contract Work Hours and Safety Standards Act.

17) Any applicable federal and state laws that pertain to member rights.

18) Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS must adjust payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. If the Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if the Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity, and DHCS included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority. DHCS will attempt to provide Contractor with timely notice of the loss of program authority.

E. The following sections of 42 Code of Federal Regulations, part 438 are inapplicable to this Contract:

1) §438.3(b) Standard Contract Provisions – Entities eligible for comprehensive risk contracts

2) §438.3(c) Standard Contract Provisions - Payment

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3) §438.3(g) Standard Contract Provisions - Provider preventable conditions

4) §438.3(o) Standard Contract Provisions - LTSS contract requirements

5) §438.3(p) Standard Contract Provisions – Special rules for HIOs

6) §438.3(s) Standard Contract Provisions – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs

7) §438.4 Actuarial Soundness

8) §438.5 Rate Development Standards

9) §438.6 Special Contract Provisions Related to Payment

10) §438.7 Rate Certification Submission

11) §438.8 Medical Loss Ratio Standards

12) §438.9 Provisions that Apply to Non-emergency Medical Transportation

13) §438.50 State Plan Requirements

14) §438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities

15) §438.56 Disenrollment: requirements and limitations

16) §438.70 Stakeholder engagement when LTSS is delivered through a managed care program

17) 438.74 State Oversight of the Minimum MLR Requirements

18) §438.104 Marketing

19) §438.106 Liability for Payment

20) §438.108 Cost Sharing

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21) §438.110 Member advisory committee

22) §438.114 Emergency and Post-Stabilization

23) §438.362 Exemption from External Quality Review

24) §438.700-730 Basis for Imposition of Sanctions

25) §438.802 Basic Requirements

26) §438.810 Expenditures for Enrollment Broker Services

27) §438.816 Expenditures for the member support system for enrollees using LTSS

F. Specific provisions of 42 Code of Federal Regulations, part 438 relating to the following subjects are inapplicable to this Contract:

1) Long Terms Services and Supports

2) Managed Long Terms Services and Supports

3) Actuarially Sound Capitation Rates

4) Medical Loss Ratio

5) Religious or Moral Objections to Delivering Services

6) Family Planning Services

7) Drug Formularies and Covered Outpatient Drugs

G. Pursuant to W&I Code section 14704, a regulation or order concerning Medi-Cal specialty mental health services adopted by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000), as in effect preceding the effective date of this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by DHCS, or until it expires by its own terms.

H. State Laws Governing this Contract:

1) Division 5, W&I Code, to the extent that these requirements are applicable to the services and functions set forth in this contract

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2) W&I Code §§ 14059.5 and 14184.402

3) W&I Code §§ 14680-14685.1

4) W&I Code §§ 14700-14727

5) Chapter 7, Part 3, Division 9, W&I Code, to the extent that these requirements are applicable to the services and functions set forth in this contract

6) Cal. Code Regs., tit. 9, § 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services, except for those regulations that are superseded by BHINs

7) Cal. Code Regs., tit. 22, §§ 50951 and 50953

8) Cal. Code Regs., tit. 22, §§ 51014.1 and 51014.2

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DEFINITIONS

1. The definitions and the definitions contained in Cal. Code Regs., tit. 9, sections 1810.100-1850.535 shall apply in this Contract unless they are superseded by BHIN. The following definitions shall also apply to this Contract unless they are superseded by BHIN. If there is a conflict between the following definitions and the definitions in Cal. Code Regs., tit. 9, sections 1810.100-1850.535, the following definitions apply. If there is a conflict with the following definitions and BHIN, the BHIN shall apply.

A. “Advance Directives” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the healthcare when the individual is incapacitated.

B. “Abuse” means, as the term described in, provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)

C. “American Indian/Alaska Native (AI/AN)” – Any person defined in 25 United States Code sections 1603(13), 1603(28), or section 1679(a), or who has been determined eligible as an Indian under 42 CFR section 136.12.

D. “Appeal” means a review by the Contractor of an adverse benefit determination.

E. “Assessment” means a service activity designed to collect information and evaluate the current status of a member's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that member. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards. (State Plan, Supplement 3 to Attachment 3.1-A, page 1 [TN 22-0023].)

F. “Member” means a Medi-Cal recipient who is currently receiving services from the Contractor.

G. "Contractor" means «Contractor_Name».

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H. "Covered Specialty Mental Health Services" are defined in Exhibit E, Attachment 2.

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

J. “Director” means the Director of DHCS.

K. “Discrimination Grievance” means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

L. “Emergency” means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency. (Health & Safety Code § 1797.07)

M. “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes an act that constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)

N. “Grievance” means an expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Grievance includes a member’s right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400)

O. “Habilitative services and devices” help a person keep, learn, or improve skills and functioning for daily living. (45 C.F.R. § 156.115(a)(5)(i))

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

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Q. "Homelessness" means The member meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

R. "Indian Health Care Provider (IHCP)" means a health care program operated by the IHS ("IHS facility"), an Indian Tribe, a Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

S. "Indian Health Service (IHS) facilities" – Facilities and/or health care programs administered and staffed by the federal Indian Health Service.

T. "Involvement in child welfare" means the member has an open child welfare services case, or the member is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the member is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A

Exhibit E – Attachment 1
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child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

U. "Juvenile justice involvement" means the member (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Members who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Members on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

V. "Managed Care Organization" (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. Part 438, and is: 1) a Federally qualified HMO that meets the advance directives requirements of Subpart I of Part 489 of 42 C.F.R.; or, 2) any public or private entity that meets the advance directive requirements and is determined by the Secretary of Health and Human Services to also meet the following conditions: i) makes the services that it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served by the entity, ii) meet the solvency standards of 42 C.F.R. 438.116. (42 C.F.R. § 438.2)

W. "Medically necessary" or "medical necessity" has the same meaning as set forth in Welfare and Institutions Code section 14059.5. For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

X. A "Network Provider" means any provider, group of providers, or entity that has a network provider agreement with a Mental Health Plan, or a

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subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department's contract with a Mental Health Plan. A network provider is not a subcontractor by virtue of the network provider agreement. (42 C.F.R. § 438.2)

Y. "Out-of-network provider" means a provider or group of providers that does not have a network provider agreement with a Mental Health Plan, or with a subcontractor. (A provider may be "out of network" for one Mental Health Plan, but in the network of another Mental Health Plan.)

Z. "Out-of-plan provider" has the same meaning as out-of-network provider.

AA. "Overpayment" means any payment made to a network provider by a Mental Health Plan to which the network provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)

BB. "Peer Support Specialist" means an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification who meets ongoing education requirements and provides services under the direction of a Behavioral Health Professional. (State Plan, Supplement 3 to Attachment 3.1-A, page 2j [TN 22-0023].)

CC. "Provider" means a person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to members by employees of the Mental Health Plan.

DD. "Physician Incentive Plans" mean any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

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EE. “PIHP” means Prepaid Inpatient Health Plan. A Prepaid Inpatient Health Plan is an entity that:

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

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

3) Does not have a comprehensive risk contract. (42 C.F.R. § 438.2)

FF. "Psychosocial Rehabilitation” means a recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member’s functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a member or a group of members. (State Plan, Supplement 3 to Attachment 3.1-A, page 2a [TN 22-0023].)

GG. “Referral and Linkages” are services and supports to connect a member with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

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HH. “Significant Change" means when there is an increase or decrease in the amount or types of services that are available, or if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits available through this contract, or when there is a change in the scope of specialty mental health services covered by this contract.

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

JJ. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association, or the American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)

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

1) 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.

2) An individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. Notwithstanding the foregoing, for purposes of Exhibit D(F) the term “subcontractor” shall include network providers.

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LL. "Therapy" means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

MM. "Treatment Planning" means a service activity to develop or update a member's course of treatment, documentation of the recommended course of treatment, and monitoring a member's progress. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

NN. "Tribal 638 Providers" – Federally recognized Tribes or Tribal organizations that contractor or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.

1) A Tribal 638 provider enrolled in Medi-Cal as an Indian Health Services-Memorandum of Agreement (IHS-MOA) provider must appear on the " List of American Indian Health Program Providers" set forth in APL 17-020, Attachment1 in order to qualify for reimbursement as a Tribal 638 Provider under BHIN 22-020.

2) A Tribal 638 provider enrolled in Medi-Cal as a Tribal FQHC provider is governed by and must enroll in Medi-Cal consistent with the Tribal FQHC criteria established in the California State Plan, 1 the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal Federally Qualified Health Center Providers," which is set forth on Attachment 2 to APL 21-008.

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OO. “Urban Indian Organizations (UIO)” – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of Title 25 of the Code of Federal Regulations.

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1. The Contractor shall provide, or arrange and pay for, the following covered specialty mental health services to members of “County_Name» County. Services shall be provided as medically necessary and approved and authorized according to State of California requirements. Services include:

   A. “Mental Health Services” are individual, group, or family-based interventions that are designed to provide a reduction of the member’s mental or emotional disability, ~~and~~ restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living, and enhanced self-sufficiency and that are not provided as components of adult residential services, crisis residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Mental health services may include contact with significant support persons or other collateral if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

   B. “Medication Support Services” include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. This service includes one or more of the following service components: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; medication education including instruction in the use, risks and benefits of, and alternatives for medication; treatment planning. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may be provided face-to-face, by telephone or by telehealth, and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

   C. “Day Treatment Intensive” is a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of members who receive services for a at least three hours per day and lasts less than 24 hours each day. This service includes one or more of the

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following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. This service may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Day treatment intensive services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)

D. "Day Rehabilitation" is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)

E. "Crisis Intervention" is an unplanned, expedited service to or on behalf of, a member to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. It may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, therapy, and referral and linkages. Crisis Intervention services may either be face-to-face or by telephone or telehealth and may be provided in a clinic setting or anywhere in the community. (State Plan, Supplement 3 to Attachment 3.1-A, page 2d [TN 22-0023].)

F. "Crisis Stabilization" is an unplanned, expedited service lasting less than 24 hours, to or on behalf of, a member to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the member or others, or

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substantially increase the risk of the member becoming gravely disabled. Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization is an all-inclusive program and no other Rehabilitative Mental Health Services are reimbursable during the same time period this service is reimbursed. Crisis stabilization may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.
Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All members receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the member 's needs will be made, to the extent resources are available. This service includes one or more of the following service components: assessment, therapy, crisis intervention, medication support services, referral and linkages. (State Plan, Supplement 3 to Attachment 3.1-A, page 2e [TN 22-0023].)

G. “Adult Residential Treatment Services” are recovery focused rehabilitative services provided in a non-institutional, residential setting for members who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2f [TN 22-0023].)

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H. "Crisis Residential Treatment Services" are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term—3 months or less) as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. This service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention. (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)

I. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by DHCS. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Services are provided in a psychiatric health facility under a multidisciplinary model and some service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis. Services include the following components: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention. These services are separate from those categorized as "Psychiatric Inpatient Hospital". (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)

J. "Peer Support Services" are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their conditions and the

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process of recovery. Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:

1) Educational Skill Building Groups, which are groups provided in a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

2) Engagement, which means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and supporting members in developing their own recovery goals and processes.

3) Therapeutic Activity, which means structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons. (State Plan, Supplement 3 to Attachment 3.1-A, page 2 [TN 22-0023].)

K. "Intensive Care Coordination (ICC)" is a targeted case management service that facilitates assessment of care planning for and coordination of services to members under age 21 who are eligible for the full scope of

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Medi-Cal services and who meet medical criteria to access SMHS. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:

1) Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;

2) Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;

3) Supports the parent/caregiver in meeting their child's needs;

4) Helps establish the CFT and provides ongoing support; and

5) Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

L. "Intensive Home Based Services (IHBS)" are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, treatment plan, therapy, rehabilitation and include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. IHBS is

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provided to members under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.

M. "Therapeutic Behavioral Services (TBS)" are intensive, individualized, short-term outpatient treatment interventions for members up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services.

N. "Therapeutic Foster Care (TFC) Services" model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services activities (plan development, rehabilitation and collateral) to children up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child. The TFC parent will provide trauma informed interventions that are medically necessary for the child. TFC is intended for children ~~youth~~ who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain specialty mental health services activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

O. "Psychiatric Inpatient Hospital Services" include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to members for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to members who were admitted to the hospital for an acute psychiatric inpatient hospital service and the member's stay at the hospital must be continued beyond the member's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the member.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services

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through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals and FFS/MC hospitals, the daily rate does not include professional services, which are billed separately from the SD/MC and FFS/MC inpatient hospital services via the SD/MC claiming system.

P. "Targeted case management" is a service that assists a member in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure member access to services and the service delivery system; monitoring of the member's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

Q. "Community-Based Mobile Crisis Intervention Services (also referred to as "Mobile Crisis Services")" are services that provide rapid response, individual assessment and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile Crisis Services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile Crisis Services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile Crisis Services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Locations may include, but are not limited to, the member's home, school, or workplace, on the street, or where a member socializes. Mobile Crisis Services claimed under this option cannot be provided in hospitals or other facility

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settings. Mobile crisis services shall be available to members experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.