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1. Service Overview

The Contractor agrees to provide to the California Department of Health Care Services (DHCS) the services described herein.

The Contractor will provide or arrange for the provision of specialty mental health services to eligible Medi-Cal beneficiaries of San Mateo County 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 Erika Cristo Telephone: (916) 713-8546 Email: Erika.Cristo@dhcs.ca.gov	**San Mateo County Behavioral Health & Recovery Services** Scott Gruendl, BHRS Assistant Director Telephone: 650-573-2491 Fax: 650-573-2841 Email: sgruendl@smcgov.org

B. Direct all inquiries to:

Department of Health Care Services 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	**San Mateo County Behavioral Health & Recovery Services** Attention: Brad Johnson 2000 Alameda de las Pulgas, Ste 235, San Mateo, CA 94403 Telephone: 650-573-2893 Fax: 650-573-2841

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	Email: brjohnson@smcgov.org

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.

5. General Authority

This Contract is entered into in accordance with the Welfare and Institutions (Welf. & Inst.) Code § 14680 through §14727. Welf. & Inst. 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 San Mateo County Behavioral Health & Recovery Services agrees to operate the Mental Health Plan (MHP) for San Mateo 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.

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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 beneficiary 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).)

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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

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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

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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 recordsof 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 beneficiaries 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 part 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

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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.

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1. Criteria for Beneficiaries to Access Specialty Mental Health Services

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 beneficiary 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 Welf. & Inst. 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 Welfare and Institutions 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 beneficiaries who meet the criteria for access to the specialty mental health delivery system.

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

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

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

1. The beneficiary 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 beneficiary'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 Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries 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 beneficiaries who meet either of the following criteria:

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

OR

2) The beneficiary meets both of the following requirements in a and b below:
   a. The beneficiary 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 beneficiary'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 beneficiary 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 beneficiaries 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 beneficiaries under the age of 21);

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

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

13) Therapeutic Foster Care (for beneficiaries 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 beneficiaries 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 (Welf. & Inst. Code 14184.402 (d)).

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B. Medi-Cal Managed Care Plan beneficiaries receive mental health disorder benefits in every classification - inpatient, outpatient, prescription drug and emergency - that the beneficiaries receive medical/surgical benefits, in compliance with 42 C.F.R. 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.

C. Services shall be provided, in accordance with the State Plan, to beneficiaries, 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 services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered specialty mental health service solely because of diagnosis, type of illness, or condition of the beneficiary. The Contractor may deny services based on Welfare and Institutions 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 beneficiary to obtain a second opinion outside the network, at no cost to the beneficiary. (42 C.F.R § 438.206(b).) At the request of a beneficiary when the Contractor or its network provider has determined that the beneficiary 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).)

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G. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with Cal. Code Regs., tit. 9, 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, at a minimum, the following day treatment intensive and day rehabilitation service components:

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

2) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation

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may include psychotherapy instead of process groups, or in addition to process groups.

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

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

D. Day treatment intensive shall additionally include:

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

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

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

E. 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

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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.

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

G. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation requirements in BHIN 22-019.

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

I. 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.

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J. 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 beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

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

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

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 beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. TBS is described in the Department of Mental Health Information Notice 08-38.

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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 IHPC 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.

3. Prohibited Payments

A. Federal Financial Participation is not available for any amount furnished to an excluded individual or entity, or at the direction of a physician during the period of exclusion 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. section 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:

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FINANCIAL REQUIREMENTS

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 amount expended 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.

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. Cost Reporting

A. The Contractor shall submit a fiscal year-end cost report no later than December 31 following the close of each fiscal year, in accordance with the Welf. & Inst. Code § 14705(c), unless that date is extended by the Department, and/or guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

Contractor's chief financial officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to, the Contractor's chief financial officer, or (3) the Contractor's auditor-controller, or equivalent. The cost report shall include both the Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual which can be accessed through the Department's Information Technology Web Services (ITWS) for the applicable year, as well as any instructions that are incorporated by reference thereto; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures developed under the Welf. & Inst. Code § 14171.

B. In accordance with Welf. & Inst. Code § 5655, the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department, in accordance with Welf.& Inst. Code § 14197.7(o)(1), may withhold payments of additional funds until the cost report that is due has been submitted.

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

7. Recovery of Overpayments

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

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).)

8. 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 beneficiary. (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 beneficiary surveys. (42 C.F.R. §§ 422.208(c)(2).)

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

9. Financial requirements

A. The Contractor shall not impose financial requirements or cumulative financial requirements, as defined in 42 C.F.R. 438.900, for any beneficiary 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.

~~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 beneficiary and provider characteristics as specified by the Department, and on services furnished to beneficiaries 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).)

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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 beneficiary encounter data to identify the provider who delivers service(s) to the beneficiary. (42 C.F.R. § 438.242(c)(1).) The Contractor shall submit all beneficiary 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. 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 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.

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

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 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.

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 beneficiaries. (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, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary 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 beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

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

2) Evaluating beneficiary 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 beneficiary/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 beneficiaries 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

G. 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 beneficiary 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 beneficiary 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 beneficiaries.

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

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, beneficiaries who have accessed specialty mental health services through the Contractor, family members, legal representatives, or other persons similarly involved with beneficiaries 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, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;

5) Designing and implementing interventions for improving performance;

6) Measuring effectiveness of the interventions;

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

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

8) Reviewing beneficiary 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).

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 beneficiary 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).)

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

6. Practice Guidelines

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 beneficiaries;

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 beneficiaries and potential beneficiaries. (42 C.F.R. § 438.236(c).)

D. The Contractor shall take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines. (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 beneficiaries 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 beneficiaries 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 beneficiary. (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 beneficiary 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 beneficiary's behavioral health needs. (42 C.F.R. § 438.210(b)(3).)

4) Notify the requesting provider and give the beneficiary 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 beneficiary's notice shall meet the requirements in Attachment 12, Section 10, paragraph A and Section 9, paragraph I and be provided within the timeframes set forth in Attachment 12, Section 10, paragraph B and Section 9, paragraph G.

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 beneficiary'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 beneficiary'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 beneficiary 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 beneficiary'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 beneficiary's request for the provision of a service. (42 C.F.R. § 431.201)

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

1. Beneficiary Enrollment

A. Medi-Cal eligible beneficiaries 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); Welf. & Inst. 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 beneficiaries, 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. If the Contractor's provider network is unable to provide necessary services, covered under this Contract, to a particular beneficiary, the Contractor shall adequately and timely cover the services out-of-network, for as long as the Contractor's provider network is unable to provide them. (42 C.F.R. § 438.206(b)(4).)

B. 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 beneficiary for services provided out-of-network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network, consistent with Cal. Code Regs., tit. 9, section 1810.365. (42 C.F.R. § 438.206(b)(5).)

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

D. 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).

4. Foster Children Placed Out-of-County

A. In accordance with Welf. & Inst. Code 14717.1, the Contractor shall be responsible to authorize, pay, provide or arrange for medically necessary specialty mental health services for foster children residing in the Contractor's county, who are placed outside of their counties of origin, unless a presumptive transfer waiver is in place. The Contractor shall follow the Mental Health and Substance Use Disorder Services Information Notices pertaining to Presumptive Transfer for Foster Children Placed Out of County (Mental Health and Substance Use Disorder

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

(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.

B. The Contractor shall accept a completed mental health assessment from the foster child's county of origin mental health plan. The Contractor may conduct additional assessments if the foster child's needs change or an updated assessment is needed to determine the child's needs and identify the needed treatment and services to address those needs.

C. When a request for a presumptive transfer waiver has been made for a foster child from the Contractor's county who is being placed outside of the Contractor's county, the Contractor shall continue to provide medically necessary specialty mental health services to that foster child until a presumptive transfer waiver determination has been made.

D. The Contractor shall be responsible to authorize, pay, provide or arrange for medically necessary specialty mental health services for foster children originally from the Contractor's county who are residing outside of the Contractor's county, if a presumptive transfer waiver is in place.

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. (Welf. & Inst. 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. (Welf. & Inst. 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 (Welf. & Inst. Code § 16125) or a child in Kin-GAP residing out-of-county with their legal guardian (Welf. & Inst. 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. Indian Beneficiaries

The Contractor shall permit an Indian beneficiary who is eligible to receive services from an 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. (42 C.F.R. § 438.14(b)(3).) 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 Indian beneficiaries who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).) 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 21-023. The Contractor shall permit Indian beneficiaries to obtain covered services from out-of-network IHCPs if the beneficiaries 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 beneficiary 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 beneficiaries. (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 beneficiaries. 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 beneficiaries in a timely manner (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 beneficiaries, 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 beneficiaries 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); Welf. & Inst. 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); Welf. & Inst. Code § 14197).

E. The Contractor shall comply with all network adequacy standards developed by the Department to implement 42 C.F.R. §§ 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. § 438.206(c)(1), the Contractor shall:

1) Meet and require its providers to meet standards for timely access to care and services, taking into account the urgency of need for services, pursuant to Welf. & Inst. Code section 14197(d), as specified in BHIN 21-023 and its enclosures, or in subsequent, guidance issued by the Department.

2) Comply with the timeliness standards specified in Cal. Code Regs., tit. 9, section 1810.405(c) and Welf. & Inst. Code § 14717.1. Those standards apply to out-of-plan services, as well as in-plan services.

3) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers

services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor, or another Mental Health Plan.

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

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

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

7) Take corrective action if there is a failure to comply with timely access requirements by a network provider.

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 21-023 and its enclosures, or in subsequent guidance issued by the Department. (42 C.F.R. § 438.207(a); Welf. & Inst. Code section 14197(f).)

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 beneficiaries for the service area.

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

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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.

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

6. Choice of Provider

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The Contractor shall provide a beneficiary'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).)

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 beneficiaries;

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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 beneficiaries. (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, § 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 beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which specialty mental health services are delivered by no more than two employees or contractors of the provider.

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

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

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

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

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

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

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

5) The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, 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; Exhibit 2, Attachment 2, Section 11 and Section 13 Paragraph B; and applicable state and federal standards.

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

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.

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

Exhibit A – Attachment 8
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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.

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.

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PROVIDER NETWORK

9. Provider Beneficiary 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 beneficiary for whom the provider is providing mental health services for any of the following:

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

2) Information the beneficiary 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 beneficiary's 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) Beneficiary grievance, appeal, and State Hearing procedures and timeframes as specified in 42 C.F.R. 438.400 through 42 C.F.R. 438.424.

2) The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing.

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

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

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5) The beneficiary'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 beneficiary 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 beneficiary.

Exhibit A – Attachment 9
DOCUMENTATION REQUIRMENTS

1. Documentation Standards

   A. The Contractor shall implement and comply with documentation standards as set forth in guidance issued by the Department in BHIN 22-019.

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 beneficiaries. (42 C.F.R. § 438.208(b).) These procedures shall meet Department requirements and shall do the following:

1) Ensure that each beneficiary 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 beneficiary. The beneficiary 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 beneficiary 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 beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries. (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 beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities. (42 C.F.R. § 438.208(b)(4).)
4) Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary 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 beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (42 C.F.R. § 438.208(b)(6).)

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 beneficiary seeking care, even prior to the determination of a diagnosis, even prior to the

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

determination of whether SMHS access criteria set forth in W&I Code section 14184.402(b)(2) are met, and even if the beneficiary 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 beneficiary 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 beneficiaries 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 beneficiary 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.

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

ii. If a beneficiary 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 beneficiaries who have established relationships with contracted mental health providers experience a change in condition requiring NSMHS. Likewise, if a beneficiary is receiving NSMHS and is determined to meet the access criteria for SMHS 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 beneficiaries 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 beneficiary

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COORDINATION AND CONTINUITY OF CARE

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.

iii. The Contractor must develop and implement written policies and procedures to ensure that beneficiaries 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 beneficiaries 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 beneficiaries. 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 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 beneficiaries. (42 C.F.R. § 438.10(c)(1).) The Contractor shall provide all written materials for beneficiaries in easily understood language, format, and alternative formats that take into consideration the special needs of beneficiaries in compliance with 42 C.F.R. § 438.10(d)(6). The Contractor shall inform beneficiaries that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

B. The Contractor shall provide the required information in this section to each beneficiary 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. § 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 beneficiary handbooks and beneficiary notices that describe the transition of care policies for beneficiaries. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3).)

F. Beneficiary 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 beneficiary 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 beneficiaries and potential beneficiaries understand the requirements and benefits of the plan. (42 C.F.R. § 438.10(c)(7).)

2. Information Provided to Beneficiaries

A. The Contractor shall provide information to beneficiaries and potential beneficiaries 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 beneficiary 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 beneficiary who was seen on a regular basis by the terminated provider. The notice to the beneficiary 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. The Contractor shall provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point. (42 C.F.R. 438.10(d)(6)(ii).)

B. The Contractor shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the potential beneficiary or beneficiary at no cost. Written material that are critical to obtaining services include, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, denial and termination notices, and the Contractor's mental health education materials. (42 C.F.R. § 438.10(d)(3).)

C. The Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, denial and termination notices, and the Contractor's mental health education materials, available in the prevalent non-English languages in the county. (42 C.F.R. § 438.10(d)(3).)

1) The Contractor shall notify beneficiaries, prospective beneficiaries, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welf. & Inst. Code § 14727(a)(1); Cal. Code Regs. tit. 9 § 1810.410, subd. (e), para. (4).)

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2) Prevalent non-English language means a language identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population (whichever is lower) in the Contractor's service area as indicated on MEDs. (42 C.F.R. § 438.10(a), Cal. Code Regs., tit. 9, § 1810.410, subd. (a), para. (3).)

D. The Contractor shall make auxiliary aids and services available upon request and free of charge to each beneficiary. (42 C.F.R. § 438.10(d)(3)-(4).) The Contractor shall also notify beneficiaries, prospective beneficiaries, and members of the public that these services are available free of charge and how to access these services. (42 C.F.R. § 438.10(d)(5)(ii)-(iii); Welf. & Inst. Code § 14727(a)(2).)

E. The Contractor shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language. (42 C.F.R. § 438.10(d)(2), (4)-(5).) Contractor shall notify beneficiaries, prospective beneficiaries, and members of the public that these services are available free of charge and how to access these services. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welf. & Inst. Code § 14727(a)(1)-(2).)

F. Nondiscrimination Notice and Taglines

1) The Contractor shall post (1) a Department-approved nondiscrimination notice and (2) language taglines in a conspicuously visible font size in English in the top 15 non-English languages in the State, and any other languages, as determined by the Department, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request auxiliary aids and services, including materials in alternative formats. The nondiscrimination notice and taglines, shall include the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit for obtaining these services, and shall be posted as follows:

a) In conspicuous physical locations where the Contractor interacts with the public;

b) On the internet website published and maintained by the Contractor, in a manner that allows beneficiaries, prospective beneficiaries, and members of the public to easily locate the information; and

c) In the beneficiary handbook, all materials critical to obtaining services, and informational notices targeted to beneficiaries and members of the public (including notices of action). (42 C.F.R. § 438.10(d)(2)-(3); Welf. & Inst. Code, § 14727(b), (c)(1)-(2).)

2) The Contractor's nondiscrimination notice and language taglines must be in a conspicuously visible font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(3), (d)(6)(ii).)

3) The Contractor shall provide information to all beneficiaries, prospective beneficiaries, and members of the public on how to file a Discrimination Grievance with:

a) The Contractor and the Department if there is a concern of discrimination based on 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. (Welf. & Inst. Code § 14727(a)(4).)

b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (Welf. & Inst. Code § 14727(a)(5).)

4. Handbook

A. The Contractor shall provide beneficiaries with a copy of the handbook and provider directory when the beneficiary 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 beneficiary handbook shall include information that enables the beneficiary to understand how to effectively use the managed care program. This information shall include, at a minimum:

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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 beneficiaries 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 beneficiary's provider. (42 C.F.R. § 438.10(g)(2)(iv).)

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

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

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

   f) Beneficiary 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 beneficiary'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. §§ 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;

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i. 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 beneficiary 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 beneficiary's appeal which is adverse to the beneficiary;

5) The fact that, when requested by the beneficiary, benefits that the Contractor seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for State Hearing within the timeframes specified for filing, and that the beneficiary 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 beneficiary. (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 beneficiaries. (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. § 438.3(i). (42 C.F.R. § 438.10(f)(3).)

D. The Contractor shall give each beneficiary 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).)

E. Consistent with 42 Code of Federal Regulations part 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 beneficiary's mailing address before the beneficiary first receives a specialty mental health service;

2) Mails a printed copy of the information upon the beneficiary's request to the beneficiary's mailing address;

3) Provides the information by email after obtaining the beneficiary's agreement to receive the information by email;

4) Posts the information on the Contractor's website and advises the beneficiary in paper or electronic form that the information is available on the internet and includes the applicable internet

addresses, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or,

5) Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information. If the Contractor provides the handbook in-person when the beneficiary first receives specialty mental health services, the date and method of delivery shall be documented in the beneficiary's file.

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 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:

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, 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).)

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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 beneficiaries. (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.

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).)

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 beneficiaries shall be updated to reflect changes in state laws governing advance directives as soon as possible, but no later than 90 days after the effective date of the change. (42 C.F.R. § 438.3(j)(4).)

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C. The Contractor shall provide adult beneficiaries 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. Beneficiary Rights

A. The parties to this contract shall comply with applicable laws and regulations relating to patients' rights, including but not limited to Wel. & Inst. Code 5325, Cal. Code Regs., tit. 9, sections 862 through 868, and 42 C. F. R. § 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 beneficiary 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. § 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 beneficiary'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).)

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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. §§ 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 beneficiary. (42 C.F.R. § 438.100(c).)

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1. General Provisions

A. The Contractor shall have a grievance and appeal system in place for beneficiaries. (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 beneficiary 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 beneficiary 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 beneficiary booklet and providing the beneficiary handbook to beneficiaries 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 beneficiaries 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 beneficiary 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 beneficiaries 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 beneficiaries 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 beneficiaries to file grievances and request appeals. (42 C.F.R. § 438.402(c)(1).) The Contractor shall have only one level of appeal for beneficiaries. (42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a).)

3) A beneficiary 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 beneficiary 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 beneficiary 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 beneficiary'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 beneficiary and with the beneficiary'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 beneficiary's authorized representative to use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf. (Cal. Code Regs., tit. 9, § 1850.205(c)(2).)

8) At the beneficiary's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing specialty mental health services to the beneficiary requesting assistance, the Contractor shall identify another individual to assist that beneficiary. (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 beneficiary 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 beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary'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 beneficiary'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 beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in §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 beneficiary or beneficiary’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 beneficiary and their representative the beneficiary’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 beneficiary and their representative the beneficiary'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 beneficiary or the provider requests expedited resolution. (42 C.F.R. § 438.406(b)(3).)

19) The Contractor's beneficiary problem resolution process shall not replace or conflict with the duties of county patient's rights advocates. (Welf. & Inst. 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 beneficiary. 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 beneficiary or the beneficiary's representative regarding the status of the beneficiary'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 beneficiary. (Cal. Code Regs., tit. 9, § 1850.205(d)(5).)

E. Provide notice, in writing, to any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal. (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 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 beneficiary 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 beneficiary may contact about the grievance. The written acknowledgement to the beneficiary 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 beneficiary'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 beneficiary'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 beneficiary 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 beneficiary'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 beneficiary, make reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary 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 beneficiary 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 beneficiary or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the beneficiary, if they could not be contacted. (Cal. Code Regs.,tit. 9, § 1850.206(c).)

F. Notify the beneficiary 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.)

4. Discrimination Grievances

A. For Discrimination Grievances:

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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. (Welf. & Inst. 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. (Welf. & Inst. 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 beneficiary 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 beneficiary, the Contractor must submit the following information regarding the complaint to the DHCS Office of Civil Rights (see California Medicaid State Plan, Section 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 beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.

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

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 beneficiary, or a provider or authorized representative acting on the beneficiary's behalf, to file an appeal orally or in writing. (42 C.F.R. § 438.402(c)(3)(ii).) The beneficiary 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 beneficiary 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 beneficiary 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 beneficiary'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 beneficiary 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 beneficiary'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 beneficiary,

make reasonable efforts to give the beneficiary prompt oral notice of the delay and notify the beneficiary 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 beneficiary 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 beneficiary'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 beneficiary 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 beneficiary and their representative the beneficiary'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 beneficiary (42 C.F.R. § 438.406(b)(5).); and

6) Provide the beneficiary and their representative the beneficiary'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).)

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

B. The Contractor shall notify the beneficiary, 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 beneficiary, the notice shall also contain:

   a) Information regarding the beneficiary's right to a State Hearing and the procedure for requesting a State Hearing, if the beneficiary 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 beneficiary'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 beneficiary 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 beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary'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:

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

2) Allow the beneficiary to file the request for an expedited appeal orally without requiring the beneficiary 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 beneficiary's expedited appeal. (42 C.F.R. § 438.410(b).)

4) Inform beneficiaries 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 beneficiaries 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 beneficiary’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 beneficiary 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 beneficiary'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 beneficiary, the Contractor shall make reasonable efforts to give the beneficiary prompt oral notice of the delay, and notify the beneficiary of the extension and the reasons for the extension, in writing, within 2 calendar days of the determination to extend the timeline. The Contractor shall resolve the appeal as expeditiously as the beneficiary'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 beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary 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 beneficiary 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 beneficiary 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 beneficiaries 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:

A. If a beneficiary 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 beneficiary and provider by the Contractor in its notice of decision or

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Notice of Adverse Benefit Determination. (42 C.F.R. § 431.206(b); 42 C.F.R. § 431.228(b).) Beneficiaries and providers shall also be informed of the following:

1) A beneficiary 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 § 438.408, the beneficiary is deemed to have exhausted the Contractor's appeals process, and the beneficiary 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 beneficiary'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 beneficiary or the beneficiary's provider certifies that following the 90 day timeframe for a State Hearing as established in 42 C.F.R. § 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. (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 beneficiary 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 beneficiary's benefits while an appeal is in process if all of the following occur:

1) The beneficiary 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).)

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

3) The beneficiary'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 beneficiary's request, the Contractor continues the beneficiary's benefits while the appeal or State Hearing is pending, the benefits must be continued until the beneficiary withdraws the appeal or request for State Hearing, the beneficiary 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 beneficiary is issued. (42 C.F.R. § 438.420(c)(1)-(3); 42 C.F.R. § 438.408(d)(2).)

D. The Contractor may recover the cost of continued services furnished to the beneficiary 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. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary'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).)

F. If the decision of an appeal reverses a decision to deny the authorization of services, and the beneficiary 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).)

G. The Contractor shall notify the requesting provider and give the beneficiary 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 beneficiary 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 beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7).)

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B. The Contractor shall give beneficiaries 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 part 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.

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 beneficiary. (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 beneficiary when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor. (Cal. Code Regs., tit. 9, § 1850.210(b).)

G. The Contractor shall deny the Contractor payment authorization request and provide the beneficiary 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, §§ 1820.220 or 1830.215. (Cal. Code Regs., tit. 9, § 1850.210(c).)

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

I. The Contractor shall provide a beneficiary 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 beneficiary 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 beneficiary on the date of the Adverse Benefit Determination or mailed to the beneficiary in accordance with Cal. Code Regs., tit. 9, § 1850.210(f)(1), and shall specify the information contained in Cal. Code Regs., tit. 9, § 1850.212(b). (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, § 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, § 51014.1, shall mean specialty mental health services that are subject to prior authorization by a Contractor pursuant to Cal. Code Regs., tit. 9, §§ 1820.100 and 1830.100. (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 beneficiaries in a timely manner.

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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).)

2) The reason for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary'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 beneficiary'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 beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6).)

7) Information about the beneficiary'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).)

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b) A statement that the beneficiary may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend, or any other person; (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 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 beneficiary, 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 beneficiary'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 beneficiary or the provider requests the extension. (42 C.F.R. § 438.404(c)(4); 42 C.F.R. 438.210(d)(1)(i).)

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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 beneficiary's best interest. (42 C.F.R. § 438.404(c)(4); 42 C.F.R. 438.210(d)(1)(ii).)

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 beneficiary written notice of the reason for the extension and inform the beneficiary 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 beneficiary'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 beneficiary'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 beneficiary'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 beneficiary requests an extension, or if the Contractor justifies to

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the Department, upon request, a need for additional information and how the extension is in the beneficiary'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).)

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 beneficiary; (42 C.F.R. § 431.213(a).)

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

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

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

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

6) A change in the beneficiary'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).)

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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).

12. Annual Grievance and Appeal Report

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

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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. §§ 438.604, 438.606 and 438.608, and 438.610. (42 C.F.R. § 438.600(b).)

2. Excluded Providers

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

B. Consistent with the requirements of 42 Code of Federal Regulations, part 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 find 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. §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.

3. Compliance Program

A. Pursuant to 42 C.F.R. § 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).)

4. Fraud Reporting Requirements

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PROGRAM INTEGRITY

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 beneficiary's circumstances that may affect the beneficiary's eligibility including changes in the beneficiary's residence or the death of the beneficiary. (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.

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).)

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5. Service Verification

Pursuant to 42 C.F.R. § 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 beneficiaries and the application of such verification processes on a regular basis. (42 C.F.R. §438.608(a), (a)(5).)

6. Disclosures

A. Disclosure of 5% or More Ownership Interest:

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

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

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

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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 part 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 part 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.

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

Exhibit A – Attachment 13
PROGRAM INTEGRITY

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 part 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 beneficiary encounter data to identify the provider who delivers service(s) to the beneficiary. (42 C.F.R. § 438.242(c)(1).) The Contractor shall submit all beneficiary 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. Insolvency

A. The Contractor shall submit data to demonstrate it has made adequate provision against the risk of insolvency to ensure that beneficiaries 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.)

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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. §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 part 438.66(c), the Contractor will submit the following to the Department (42 C.F.R. §438.604(b).):

1) Enrollment and disenrollment data;

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REPORTING REQUIREMENTS

2) Member grievance and appeal logs;

3) Provider complaint and appeal logs;

4) The results of any beneficiary 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 beneficiaries. 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 Welfare & Institutions 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 beneficiary 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
   The Contractor shall ensure that Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

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PEER SUPPORT SERVICES

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.