

File No. 220417

Committee Item No. 7

Board Item No. \_\_\_\_\_

## COMMITTEE/BOARD OF SUPERVISORS

### AGENDA PACKET CONTENTS LIST

Committee: Gov. Audit and Oversight Comm.

Date May 19, 2022

Board of Supervisors Meeting

Date \_\_\_\_\_

#### Cmte Board

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| <input type="checkbox"/>            | <input type="checkbox"/> | Budget and Legislative Analyst Report        |
| <input type="checkbox"/>            | <input type="checkbox"/> | Youth Commission Report                      |
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| <input type="checkbox"/>            | <input type="checkbox"/> | Memorandum of Understanding (MOU)            |
| <input type="checkbox"/>            | <input type="checkbox"/> | Grant Information Form                       |
| <input type="checkbox"/>            | <input type="checkbox"/> | Grant Budget                                 |
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| <input type="checkbox"/>            | <input type="checkbox"/> | Form 126 - Ethics Commission                 |
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**OTHER** (Use back side if additional space is needed)

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Completed by: Victor Young

Date May 13, 2022

Completed by: \_\_\_\_\_

Date \_\_\_\_\_

1 [Agreement Amendment - California Department of Health Care Services - Mental Health Plan  
- \$0]

2  
3 **Resolution approving Mental Health Plan Agreement Amendment No. 17-94609 A01,**  
4 **between Department of Public Health (DPH), Community Behavioral Health Services**  
5 **and the California Department of Health Care Services, for the San Francisco Mental**  
6 **Health Plan, to update the terms and conditions reflecting changes that memorialize**  
7 **federal parity regulations, in the amount of \$0 for the term of July 1, 2017, through June**  
8 **30, 2022, to commence following approval by the Board of Supervisors; and to**  
9 **authorize DPH to enter into amendments or modifications to the agreement prior to its**  
10 **final execution by all parties that do not materially increase the obligations or liabilities**  
11 **to the City and are necessary to effectuate the purposes of the agreement or this**  
12 **Resolution.**

13  
14 WHEREAS, California Welfare and Institutions (W&I) Code, § 14712 directs the  
15 California Department of Health Care Services (DHCS) to implement and administer Managed  
16 Mental Health Care for Medi-Cal eligible residents through agreements with Mental Health  
17 Plans (MHP) in California counties; and

18 WHEREAS, MHPs are required to provide or arrange for the provision of Specialty  
19 Mental Health Services to beneficiaries in their counties that meet medical necessity criteria,  
20 consistent with the beneficiaries' mental health treatment needs and goals; and

21 WHEREAS, This Mental Health Plan Agreement sets forth the scope of service and  
22 requirements related to the provision of these services for San Francisco County; and

23 WHEREAS, The Department of Public Health, Community Behavioral Health Services  
24 (DPH-CBHS) operates the Mental Health Plan for the City and County of San Francisco; and

1           WHEREAS, The Center for Medicare and Medicaid (CMS) promulgated revisions to  
2 the managed care regulations applicable to MHPs; and

3           WHEREAS, CMS required DHCS to develop agreements with MHPs, effective July 1,  
4 2017, reflecting these changes as a condition of payment of federal financial participation 42  
5 C.F.R., § 438.802(a) and DHCS is amending contracts with MHPs, that took effect July 1,  
6 2017, to update the terms and conditions reflecting these changes that memorialize federal  
7 parity regulations; and

8           WHEREAS, A copy of the original agreement is on file with the Clerk of the Board of  
9 Supervisors in File No. 180715; now, therefore, be it

10          RESOLVED, That the Board of Supervisors hereby authorizes DPH-CBHS, on behalf  
11 of the City and County of San Francisco, to execute Amendment No. 17-94609 A01 with  
12 DHCS for the Mental Health Plan, in the amount of \$0, for a total agreement term of July 1,  
13 2017, through June 30, 2022; and, be it

14          FURTHER RESOLVED, That the Board of Supervisors authorizes the Director of  
15 Behavioral Health Services and Mental Health to enter into any amendments or modifications  
16 to the agreement, prior to its final execution by all parties, that the Department determines, in  
17 consultation with the City Attorney, are in the best interests of the City, do not otherwise  
18 materially increase the obligations or liabilities of the City, are necessary or advisable to  
19 effectuate the purposes of the agreement, and are in compliance with all applicable laws; and,  
20 be it

21          FURTHER RESOLVED, That within thirty (30) days of the Mental Health Plan  
22 Agreement being fully executed by all parties, the DPH Director of Behavioral Health Services  
23 and Mental Health SF shall provide the final contract to the Clerk of the Board for inclusion in  
24 File No.\_\_\_\_\_.  
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RECOMMENDED

    /s/    

Dr. Grant Colfax

Director of Health

**STANDARD AGREEMENT - AMENDMENT**

STD 213A (Rev. 4/2020)

 CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED 148 PAGES

AGREEMENT NUMBER

17-94609

AMENDMENT NUMBER

A01

Purchasing Authority Number

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

CONTRACTING AGENCY NAME

Department of Health Care Services

CONTRACTOR NAME

San Francisco Community Behavioral Health Services

2. The term of this Agreement is:

START DATE

July 1, 2017

THROUGH END DATE

June 30, 2022

3. The maximum amount of this Agreement after this Amendment is:

\$0.00 (Zero Dollars)

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. The effective date of this amendment is the date approved by DHCS.

II. Purpose of Amendment: Updating terms and conditions to comply with federal regulations as determined by the Centers for Medicare and Medicaid Services.

(Continued on next pages)

*All other terms and conditions shall remain the same.**IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.***CONTRACTOR**

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)

San Francisco Community Behavioral Health Services

CONTRACTOR BUSINESS ADDRESS

1380 Howard St.

CITY

San Francisco

STATE

CA

ZIP

94103

PRINTED NAME OF PERSON SIGNING

TITLE

CONTRACTOR AUTHORIZED SIGNATURE

DATE SIGNED

**STATE OF CALIFORNIA**

CONTRACTING AGENCY NAME

Department of Health Care Services

CONTRACTING AGENCY ADDRESS

1501 Capitol Avenue MS 4200

CITY

Sacramento

STATE

CA

ZIP

95814

PRINTED NAME OF PERSON SIGNING

TITLE

CONTRACTING AGENCY AUTHORIZED SIGNATURE

DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL

EXEMPTION (If Applicable)

Exempt per: WIC 14703

III. Certain changes made in this amendment are shown as: Text additions are displayed in bold and underline (i.e. **bold and underline**). Text deletions are displayed as strike through text (i.e. ~~strike~~).

IV. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A A1 - Scope of Work (2 pages)

All references to Exhibit A – Scope of Work, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A A1 - Scope of Work. The attached revised exhibit hereby replaces Exhibit A – Scope of Work.

V. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 1 A1 – Organization and Administration (6 pages)

All references to Exhibit A, Attachment 1 – Organization and Administration, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 1 A1 - Organization and Administration. The attached revised exhibit hereby replaces Exhibit A, Attachment 1 – Organization and Administration.

VI. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 2 A1 – Scope of Services (10 pages)

All references to Exhibit A, Attachment 2 – Scope of Services, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 2 A1 - Scope of Services. The attached revised exhibit hereby replaces Exhibit A, Attachment 2 – Scope of Services.

VII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 3 A1 – Financial Requirements (7 pages)

All references to Exhibit A, Attachment 3 – Financial Requirements, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A,

Attachment 3 A1 - Financial Requirements. The attached revised exhibit hereby replaces Exhibit A, Attachment 3 – Financial Requirements.

- VIII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 4 A1 – Management Information Systems (2 pages)

All references to Exhibit A, Attachment 4 – Management Information Systems, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 4 A1 - Management Information Systems. The attached revised exhibit hereby replaces Exhibit A, Attachment 4 – Management Information Systems.

- IX. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 5 A1 – Quality Improvement System (6 pages)

All references to Exhibit A, Attachment 5 – Quality Improvement System, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 5 A1 - Quality Improvement System. The attached revised exhibit hereby replaces Exhibit A, Attachment 5 – Quality Improvement System.

- X. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 6 A1 – Utilization Management Program (4 pages)

All references to Exhibit A, Attachment 6 – Utilization Management Program, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 6 A1 - Utilization Management Program. The attached revised exhibit hereby replaces Exhibit A, Attachment 6 – Utilization Management Program.

- XI. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 7 A1 – Access and Availability of Services (6 pages)

All references to Exhibit A, Attachment 7 – Access and Availability of Services, in any exhibit incorporated into this agreement shall hereinafter be deemed to read

Exhibit A, Attachment 7 A1 - Access and Availability of Services. The attached revised exhibit hereby replaces Exhibit A, Attachment 7 – Access and Availability of Services.

- XII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 8 A1 – Provider Network (12 pages)

All references to Exhibit A, Attachment 8 – Provider Network, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 8 A1 - Provider Network. The attached revised exhibit hereby replaces Exhibit A, Attachment 8 – Provider Network.

- XIII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 9 A1 – Documentation Requirements (7 pages)

All references to Exhibit A, Attachment 9 – Documentation Requirements, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 9 A1 - Documentation Requirements. The attached revised exhibit hereby replaces Exhibit A, Attachment 9 – Documentation Requirements.

- XIV. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 10 A1 – Coordination and Continuity of Care (2 pages)

All references to Exhibit A, Attachment 10 – Coordination and Continuity of Care, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 10 A1 - Coordination and Continuity of Care. The attached revised exhibit hereby replaces Exhibit A, Attachment 10 – Coordination and Continuity of Care.

- XV. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 11 A1 – Information Requirements (13 pages)

All references to Exhibit A, Attachment 11 – Information Requirements, in any exhibit incorporated into this agreement shall hereinafter be deemed to read



Exhibit A, Attachment 11 A1 - Information Requirements. The attached revised exhibit hereby replaces Exhibit A, Attachment 11 – Information Requirements.

- XVI. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 12 A1 – Beneficiary Problem Resolution (23 pages)

All references to Exhibit A, Attachment 12 – Beneficiary Problem Resolution, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 12 A1 - Beneficiary Problem Resolution. The attached revised exhibit hereby replaces Exhibit A, Attachment 12 – Beneficiary Problem Resolution.

- XVII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 13 A1 – Program Integrity (7 pages)

All references to Exhibit A, Attachment 13 – Program Integrity, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 13 A1 - Program Integrity. The attached revised exhibit hereby replaces Exhibit A, Attachment 13 – Program Integrity.

- XVIII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment 14 A1 – Reporting Requirements (3 pages)

All references to Exhibit A, Attachment 14 – Reporting Requirements, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment 14 A1 - Reporting Requirements. The attached revised exhibit hereby replaces Exhibit A, Attachment 14 – Reporting Requirements.

- XIX. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit B A1 – Budget Detail and Payment Provisions (5 pages)

All references to Exhibit B – Budget Detail and Payment Provisions, in any exhibit incorporated into this agreement shall hereinafter be deemed to read

Exhibit B A1 - Budget Detail and Payment Provisions. The attached revised exhibit hereby replaces Exhibit B – Budget Detail and Payment Provisions.

- XX. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit E A1 – Additional Provisions (17 pages)

All references to Exhibit E – Additional Provisions, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit E A1 - Additional Provisions. The attached revised exhibit hereby replaces Exhibit E – Additional Provisions.

- XXI. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit E, Attachment 1 A1 – Definitions (5 pages)

All references to Exhibit E, Attachment 1 – Definitions, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit E, Attachment 1 A1 - Definitions. The attached revised exhibit hereby replaces Exhibit E, Attachment 1 – Definitions.

- XXII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit E, Attachment 2 A1 – Service Definitions (6 pages)

All references to Exhibit E, Attachment 2 – Service Definitions, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit E, Attachment 2 A1 – Service Definitions. The attached revised exhibit hereby replaces Exhibit E, Attachment 2 – Service Definitions.

- XXIII. All other terms and conditions shall remain the same.

**Exhibit A A1  
SCOPE OF WORK**

**1. Service Overview**

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 Francisco 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:

<p><b>Department of Health Care Services</b> Erika Cristo Telephone: (916) 713-8546 Email: <a href="mailto:Erika.Cristo@dhcs.ca.gov">Erika.Cristo@dhcs.ca.gov</a></p>	<p><b>San Francisco Community Behavioral Health Services</b> Hillary Kunins, MD, Behavioral Health Director Telephone: 415-255-3440 Fax: 415-255-3567 Email: <a href="mailto:hillary.kunins@sfdph.org">hillary.kunins@sfdph.org</a></p>
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B. Direct all inquiries to:

<p><b>Department of Health Care Services</b> Medi-Cal Behavioral Health Division Attention: Dee Taylor 1501 Capitol Avenue, MS 2702 Sacramento, CA, 95814 Telephone: (916) 713-8509 Email: <a href="mailto:Dee.Taylor@dhcs.ca.gov">Dee.Taylor@dhcs.ca.gov</a></p>	<p><b>San Francisco Community Behavioral Health Services</b> Attention: Hillary Kunins, MD 1380 Howard St. San Francisco, CA 94103 Telephone: 415-255-3440 Fax: 415-255-3567 Email: <a href="mailto:hillary.kunins@sfdph.org">hillary.kunins@sfdph.org</a></p>
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**Exhibit A A1**  
**SCOPE OF WORK**

- 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 §147267. 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 Francisco Community Behavioral Health Services agrees to operate the Mental Health Plan (MHP) for San Francisco 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. ~~Americans with Disabilities Act~~ Electronic and IT Accessibility Requirements Under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990**

Contractor agrees to ensure that deliverables developed and produced pursuant to this Agreement shall comply with the accessibility requirements of Sections 7405 and 11135 of the California Government Code, Section 508 of the Rehabilitation Act of 1973 ~~and the Americans with Disabilities 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 (42 U.S.C. § 12101 et seq.). 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 sections 7405 and 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 14 for a detailed description of the services to be performed.

**Exhibit A – Attachment 1 A1**  
**ORGANIZATION AND ADMINISTRATION**

**1. Implementation Plan**

The Contractor shall comply with the provisions of the Contractor's Implementation Plan as approved by the Department, including the administration of 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); ~~42 U.S.C. § 1320c-5.~~)
- C. The Contractor shall not have types of relationships prohibited by this section with an excluded, debarred, or suspended individual, provider, or entity as follows:
- 1) A director, officer, agent, managing employee, or partner of the Contractor. (42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1).)

**Exhibit A – Attachment 1 A1  
ORGANIZATION AND ADMINISTRATION**

- 2) A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230. (42 C.F.R. § 438.610(c)(2).)
  - 3) A person with beneficial ownership of 5 percent or more of the Contractor's equity. (42 C.F.R. § 438.610(c)(3).)
  - 4) An individual convicted of crimes described in section 1128(b)(8)(B) of the Act. (42 C.F.R. § 438.808(b)(2).)
  - 5) A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract. (42 C.F.R. § 438.610(c)(4).)
  - 6) The Contractor shall not employ or contract with, directly or indirectly, such individuals or entities for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services (or the establishment of policies or provision of operational support for such services). (42 C.F.R. § 438.808(b)(3).)
- D. The Contractor shall provide to the Department written disclosure of any prohibited affiliation identified by the Contractor or its subcontractors. (42 C.F.R. §438.608(c)(1).)

**3. Delegation**

Unless specifically prohibited by this contract or by federal or state law, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. 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. § ~~483~~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

**Exhibit A – Attachment 1 A1  
ORGANIZATION AND ADMINISTRATION**

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.

**Exhibit A – Attachment 1 A1  
ORGANIZATION AND ADMINISTRATION**

- 8) Provisions for full and partial revocation of the subcontract, delegated activities or obligations, or application of other remedies permitted by state or federal law when the Department or the Contractor determine that the subcontractor has not performed satisfactorily. (42 C.F.R. § 438.230(c)(1)(iii).)
- 9) The nondiscrimination and compliance provisions of this contract as ~~described in Exhibit E, Section 5, Paragraph C and Section 6, Paragraph C.~~
- 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)~~3(h).) 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, then. (42 C.F.R. § 438.230(c)(3)(iv).)
- 11) The Department's inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained 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.



**Exhibit A – Attachment 1 A1  
ORGANIZATION AND ADMINISTRATION**

- 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. 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).)

**Exhibit A – Attachment 1 A1  
ORGANIZATION AND ADMINISTRATION**

- C. No public officials at any level of local government shall make, participate in making, or attempt to use their official positions to influence a decision made within the scope of this Contract in which they know or have reason to know that they have a financial interest. (Gov. Code §§ 87100, 87103; Cal. Code Regs., tit. 2, § 18704; 42 C.F.R. §§ 438.3(f)(2).)
- 1) If a public official determines not to act on a matter due to a conflict of interest within the scope of this Contract, the Contractor shall notify the Department by oral or written disclosure. (Cal. Code Regs., tit. 2, § 18707; 42 C.F.R. § 438.3(f)(2).)
  - 2) Public officials, as defined in Government Code section 87200, shall follow the applicable requirements for disclosure of a conflict of interest or potential conflict of interest, once it is identified, and recuse themselves from discussing or otherwise acting upon the matter. (Gov. Code § 87105, Cal. Code Regs., tit. 2, § 18707(a); 42 C.F.R. § 438.3(f)(2).)
- D. 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) Contractor shall submit documentation to the Department of employees (current and former State employees) who may present a conflict of interest.

**Exhibit A – Attachment 2 A1  
SCOPE OF SERVICES**

**1. Provision of Services**

A. The Contractor shall provide or arrange, and pay for, the following medically necessary covered **specialty mental health services** to beneficiaries, as defined for the purposes of this contract, of San Francisco County. **See Exhibit E, Attachment 2, Service Definitions, for detailed descriptions of the specialty mental health services SMHS-listed below:**

- 1) Mental health services;
- 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; ~~and~~

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SCOPE OF SERVICES**

- 15) Targeted Case Management; **and**
- 16) **For beneficiaries under 21 years of age, 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)).**

See Exhibit E, Attachment 2, Service Definitions for detailed descriptions of the SMHS listed above.

- 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). Contractor is only required to provide inpatient and outpatient specialty mental health services, as provided for in this Contract, 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 medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary. **Any Medi-Cal services not covered by the scope of this contract will be provided through other Medi-Cal delivery systems.**
- D. The Contractor shall ensure that all medically necessary covered **s**pecialty **m**ental **h**ealth **s**ervices are sufficient in amount, duration, or 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 **s**pecialty **m**ental **h**ealth **s**ervice solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in the California Code of Regulations, title 9, sections 1820.205, 1830.205, and 1830.210. (42 C.F.R. § 438.210(a)(2) and (3).)
- E. The Contractor shall make all medically necessary covered **s**pecialty **m**ental **h**ealth **s**ervices available in accordance with California Code of

**Exhibit A – Attachment 2 A1  
SCOPE OF SERVICES**

Regulations., title 9, sections 1810.345, 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 medical necessity criteria, the contractor shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (Cal. Code Regs., tit. 9, § 1810.405(e).)
- G. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with California Code of Regulations., title 9, section 1830.225 and 42 Code of Federal Regulations part 438.3(l).
- ~~H. In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor shall not exclude a beneficiary solely on the ground that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.~~

**2. Requirements for Day Treatment Intensive and Day Rehabilitation**

- A. The Contractor shall require providers to request payment **prior** authorization for day treatment intensive and day rehabilitation services, **in accordance with Information Notice 19-026 and any subsequent departmental notices.**
  - ~~1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.~~
  - ~~2) At least every three months for continuation of day treatment intensive.~~
  - ~~3) At least every six months for continuation of day rehabilitation.~~

**Exhibit A – Attachment 2 A1  
SCOPE OF SERVICES**

- ~~4) Contractor shall also require providers to request authorization for mental health services, as defined in California Code of Regulations, title 9, section 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in California Code of Regulations, title 9, sections 1810.216 and 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.~~
- ~~B. The Contractor shall not delegate the payment authorization function to providers. When the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the payment authorization function does not include staff involved in the provision of day treatment intensive, day rehabilitation services, or mental health services provided concurrent to day treatment intensive or day rehabilitation services.~~
- B. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of California Code of Regulations, title 9, sections §§ 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) Community meetings. These meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and beneficiaries. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that beneficiaries or staff wish to discuss to elicit support of the group and conflict resolution. Community meetings shall:
    - a) For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.
    - b) For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist,

**Exhibit A – Attachment 2 A1  
SCOPE OF SERVICES**

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

- 2) Therapeutic milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.
- 3) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.
- 4) Skill-building groups. In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.
- 5) Adjunctive therapies. These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the

**Exhibit A – Attachment 2 A1  
SCOPE OF SERVICES**

modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs identified in the client plan.

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 waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.
- 2) Mental Health Crisis Protocol. The Contractor shall ensure that there is an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.
- 3) Written Weekly Schedule. The Contractor shall ensure that a weekly detailed schedule is available to beneficiaries and as



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**SCOPE OF SERVICES**

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 California Code of Regulations, title 9, section 1840.350, for day treatment intensive, and California Code of Regulations, **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 Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.
- F. If a beneficiary is unavoidably absent and does not attend all of the scheduled hours of the day rehabilitation or day treatment intensive program, the Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day. The Contractor shall require that a separate entry be entered in the beneficiary record documenting the reason for the unavoidable absence and the total time (number of hours

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**SCOPE OF SERVICES**

and minutes) the beneficiary actually attended the program that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

- G. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation standards described in Attachment 9 of this exhibit. The documentation shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the beneficiary actually attended the program. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist, or a registered nurse who is either staff to the day treatment intensive program or the person directing the services.
- 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

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the date the provider begins delivering day treatment intensive or day rehabilitation.

- J. Additional higher or more specific standards. The Contractor shall retain the authority to set additional higher or more specific standards than those set forth in this contract, provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.
- K. 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 or operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

**3. Therapeutic Behavioral Services**

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SCOPE OF SERVICES**

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

**Exhibit A – Attachment 3 A1  
FINANCIAL REQUIREMENTS**

**1. Provider Compensation**

The Contractor shall ensure that no payment is made to a network provider other than payment the Contractor makes for services covered under this Contract, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 Code of Federal Regulations in chapter IV, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the State Plan. (42 C.F.R. § 438.60.)

**2. Payments for Indian Health Care Providers**

- A. Contractor shall make payment to all Indian Health Care Providers (IHCPs) in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 §§ C.F.R. 447.454 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. 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).)

**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**

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FINANCIAL REQUIREMENTS**

**the Welf. & Inst. Code § 14705(c)**, unless that date is extended by the Department, ~~in accordance with the Welf. & Inst. Code § 14705(e)~~, and/or guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the Contractor's chief financial officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to, the Contractor's chief financial officer, or (3) the Contractor's auditor-controller, or equivalent. The cost report shall include both Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual which can be accessed through the Department's Information Technology Web Services (ITWS) for the applicable year, as well as any instructions that are incorporated by reference thereto; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures developed under the Welf. & Inst. Code § 14171.

- B. In accordance with Welf. & Inst. Code § 5655, the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department, in accordance with Welf. & Inst. Code § ~~14197.7(o)(1)~~~~14712(e)~~, may withhold payments of additional funds until the cost report that is due has been submitted.
- C. Upon receipt of an amended cost report, which includes reconciled units of service, and a certification statement that has been signed by the Contractor's Mental Health Director and one of the following: 1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county's auditor controller, or equivalent, the Department shall preliminarily settle the cost report. After completing its preliminary settlement, the Department shall so notify the Contractor if additional FFP is due to the Contractor. The Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority. If funds are due to the State,

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the Department shall invoice the Contractor and the Contractor shall return the overpayment to the Department.

**7. Recovery of Overpayments**

- A. The Contractor, and any subcontractor or any network provider of the Contractor, shall report to the Department within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services. (42 C.F.R. § 438.608(c)(3).)
- B. The Contractor, or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures that include provision for the suspension of payments to a network provider for which the State, or 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. (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 (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.



**Exhibit A – Attachment 3 A1  
FINANCIAL REQUIREMENTS**

- 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)(f)~~.)
- 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. **Beneficiary Liability for Payment**~~

- ~~B. The Contractor or an affiliate, vendor, contractor, or subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments. (Cal. Code Regs., tit. 9, § 1810.365 (a).)~~
- ~~C. The Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent; for costs of covered services for which~~

**Exhibit A – Attachment 3 A1  
FINANCIAL REQUIREMENTS**

~~the State does not pay the Contractor; for costs of covered services for which the State or the Contractor does not pay the Contractor's network providers; for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary. 42 C.F.R. § 438.106 and Cal. Code Regs. tit 9, § 1810.365(c).~~

- ~~D. The Contractor shall ensure its subcontractors and providers do not bill beneficiaries, for covered services, any amount greater than would be owed if the Contractor provided the services directly (42 C.F.R. § 483.106(c)).~~

**11. Cost Sharing**

- ~~A. The Contractor shall ensure that any cost sharing imposed on beneficiaries is in accordance with 42 Code of Federal Regulations part 447.50 through 447.82. (42 C.F.R. § 438.108.)~~
- ~~B. The Contractor shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral. (42 C.F.R. § 447.56(a)(1)(x).)~~

**10. ICD- 10**

- A. The Contractor shall use the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as the clinical tool to make diagnostic determinations.
- B. Once a DSM-5 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).
- C. 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) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient Medi-Cal specialty mental

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FINANCIAL REQUIREMENTS**

health services listed in ~~Mental Health and Substance Use Disorder Services (MHSUDS)~~ **Behavioral Health** Information Notice **(BHIN) 17-004E20-043**.

- D. The lists of covered ICD-10 diagnosis codes in ~~MHSUDS Information Notice~~ **BHIN 17-004E20-043** are subject to change and the Department may update them during the term of this contract. Changes to the lists of covered ICD-10 covered diagnoses do not require an amendment to this contract and the Department may implement these changes via ~~Mental Health and Substance Use Disorder Services~~ Information Notices.

**Exhibit A – Attachment 4 A1**  
**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).)

**Exhibit A – Attachment 4 A1  
MANAGEMENT INFORMATION SYSTEMS**

- C. 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. Medi-Cal Eligibility Data System (MEDS) and MEDS Monthly Extract File (MMEF)~~**

~~The Contractor shall enter into a Medi-Cal Privacy and Security Agreement (PSA) with the Department prior to obtaining access to MEDS and the MEDS monthly extract file (MMEF). The Contractor agrees to comply with the provisions as specified in the PSA. The County Mental Health Director or his or her authorized designee shall certify annually that Contractor is in compliance with the PSA agreement. Failure to comply with the terms of the agreement will result in the termination of access to MEDS and MMEF. (42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300(a); 42 C.F.R. § 431.306(b); Welf. & Inst. Code § 14100.2(a).)~~

**Exhibit A – Attachment 5 A1  
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 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. 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 A1  
QUALITY IMPROVEMENT SYSTEM**

- 1) Surveying beneficiary/family satisfaction with the Contractor's services at least annually;
  - 2) Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
  - 3) Evaluating requests to change persons providing services at least annually.
  - 4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.
- 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. Contractor's QAPI Program shall include Performance Improvement Projects as specified in paragraph 5.

**2. Quality Improvement (QI) Work Plan**

- A. 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, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416(a);

**Exhibit A – Attachment 5 A1  
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



**Exhibit A – Attachment 5 A1  
QUALITY IMPROVEMENT SYSTEM**

document QI Committee meeting minutes regarding decisions and actions taken.

- 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 participation in the planning, design and execution of the QI Program** by the Contractor's practitioners and providers, ~~as well as beneficiaries~~ **who have accessed specialty mental health services through the Contractor, and family members, legal representatives, or other persons similarly involved with beneficiaries** ~~in the planning, design and execution of the QI Program,~~ as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(2)(A-C).
- F. 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;

**Exhibit A – Attachment 5 A1  
QUALITY IMPROVEMENT SYSTEM**

- 7) Incorporating successful interventions into the Contractor's operations as appropriate; and
- 8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

**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).)

**Exhibit A – Attachment 5 A1  
QUALITY IMPROVEMENT SYSTEM**

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

**6. Practice Guidelines**

- 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** ~~contracting health care professionals~~; and
  - 4) They are reviewed and updated periodically as appropriate. (42 C.F.R. § 438.236(b).)
- C. 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. 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 A1  
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 California Code of Regulations., title 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 medical necessity and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration or 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 A1  
UTILIZATION MANAGEMENT PROGRAM**

**2. Service Authorization**

- A. Contractor shall implement mechanisms to assure authorization decision standards are met **in accordance with Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 19-026, 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. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:~~

**Exhibit A – Attachment 6 A1  
UTILIZATION MANAGEMENT PROGRAM**

- ~~1) The beneficiary, or the provider, requests extension; or~~
- ~~2) The Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the beneficiary's interest. (42 C.F.R. § 438.210(d)(1))~~

**B. The Contractor shall comply with authorization timeframes in accordance with MHSUDS Information Notice 19-026, 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).)**

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) 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). The Contractor that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize,

**Exhibit A – Attachment 6 A1  
UTILIZATION MANAGEMENT PROGRAM**

food, shelter or clothing. (Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

~~D. The Contractor may not require prior authorization for an emergency admission to a psychiatric health facility when the beneficiary has an emergency psychiatric condition. (Cal. Code Regs., tit. 9, §§ 1810.216 and 1830.245).~~

~~E. A Contractor shall authorize out of network services when a beneficiary with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospital services or psychiatric health facility services (Cal. Code Regs., tit. 9 §§ 1830.220, 1810.216, 1820.225, and 1830.245).~~

F. 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 A1**  
**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. **CA**, 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 medical necessity criteria for 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 medical necessity criteria for 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 medical necessity criteria for 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, or 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 A1  
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 California Code of Regulations, title 9, section 1810.365. (42 C.F.R. § 438.206(b)(5).)
- C. Contractor shall comply with the requirements of California Code of Regulations, title 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, 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. Procedures for ~~Serving Child Beneficiaries~~ Foster Children Placed Out-of-County**

- A. In accordance with Cal. Code Regs., tit. 9, § 1830.220 Welf. & **Inst. Code 14717.1**, the Contractor in the **foster** child's county of origin **residence** shall **be responsible to authorize, pay,** provide or arrange for medically

**Exhibit A – Attachment 7 A1  
ACCESS AND AVAILABILITY OF SERVICES**

necessary specialty mental health services for ~~the foster~~ children ~~in a foster care aid code~~ 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 (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 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.
- ~~E. The Contractor shall provide specialty mental health services and accept an assessment, if one exists, of needed specialty mental health services for the foster child from the MHP in the county of original jurisdiction. Nothing should preclude the Contractor from updating the assessment of conducting a new assessment if clinically indicated, but these updates or new assessments shall not delay the timely provision of specialty mental health services to the foster child.~~

**Exhibit A – Attachment 7 A1  
ACCESS AND AVAILABILITY OF SERVICES**

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

- ~~1) Client Assessment,~~
- ~~2) Client Plan,~~
- ~~3) Service Authorization Request,~~
- ~~4) Client Assessment Update,~~
- ~~5) Progress Notes – Day Treatment Intensive Services,~~
- ~~6) Progress Notes – Day Rehabilitation Services,~~
- ~~7) Organizational Provider Agreement (Standard Contract).~~

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

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

- A. The Contractor shall ensure that the MHP in the child's adoptive parents' county of residence provides **or arrange for the provision of** medically necessary specialty mental health services to a child in an ~~an~~**the** Adoption Assistance Program (AAP) aid code residing **within their adoptive parents' county of residence in the Contractor's county. These services are to be provided** outside his or her county of origin in the same way as the MHP ~~Contractor~~**Contractor** would provide services to any **other** in-county child for whom the MHP ~~Contractor county~~**Contractor 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 MHP in the child's legal guardians' county of residence ~~The~~**Contractor** shall provide **or arrange for the provision of** medically

**Exhibit A – Attachment 7 A1  
ACCESS AND AVAILABILITY OF SERVICES**

necessary specialty mental health services to a child in ~~the a-Kinship-~~**Guardian Assistance Program (Kin-GAP)** aid code residing **within their legal guardian's county of residence in the Contractor's county.** **These services are to be provided** ~~outside his or her county of origin~~ in the same way that ~~it~~**the Contractor** would provide services to any other child for whom the ~~MHP~~**Contractor county** is listed as the county of responsibility ~~in~~**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 19-026 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 19-026 and any applicable Departmental notices issued after the effective date of this contract,** when processing or submitting authorization requests for children in a foster care AAP, or Kinship Guardian Assistance Payment (Kin-GAP,) aid code living outside his or her **their** county of origin.
- E. ~~The Contractor shall use the standard forms issued by the Department, or the electronic equivalent of those forms generated from the Contractor's Electronic Health Record System, when a child in a foster care aid code is placed outside of his/her county of origin. The standard forms are:~~
- ~~1) Client Assessment,~~
  - ~~2) Client Plan,~~
  - ~~3) Service Authorization Request,~~
  - ~~4) Client Assessment Update,~~
  - ~~5) Progress Notes – Day Treatment Intensive Services,~~

**Exhibit A – Attachment 7 A1**  
**ACCESS AND AVAILABILITY OF SERVICES**

- 6) ~~Progress Notes – Day Rehabilitation Services.~~  
7) ~~Organizational Provider Agreement (Standard Contract).~~

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

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

**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 his or her 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).) **Contractor shall document good-faith efforts to contract with all IHCPs in Contractor's county. If Contractor does not contract with a IHCP in Contractor's county, Contractor must submit a written explanation to the Department of why it failed to contract with that IHCP, with supporting documentation.** 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 A1  
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

**Exhibit A – Attachment 8 A1  
PROVIDER NETWORK**

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 20-023 and its attachments, or in subsequent guidance issued in BHINs** developed 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~~ **must** submit to the Department a request for **an** Alternate Access Standards **upon notification that the Contractor is deficient in network adequacy standards**. The Department will evaluate requests and grant appropriate exceptions to the state developed standards, **as specified in BHIN 20-023 and its attachments, or in subsequent guidance issued by BHINs by the Department.** (42 C.F.R. § 438.68(a), (d), 438.206(a); **Welf. & Inst. Code § 14197.**)
- E. **The Contractor shall comply with network adequacy standards developed by the Department to implement 42 C.F.R. §§ 438.68, 438.206, and 438.207, including provider ratios and other network capacity requirements, as specified in BHIN 20-023 and its attachments, or in subsequent guidance issued by BHIN by the Department.**
4. **Timely Access**
- A. Timely Access. In accordance with 42 C.F.R. § 438.206(c)(1), the Contractor shall: ~~comply with the requirements set forth in Cal. Code Regs., tit. 9, §1810.405, including the following:~~
- 1) Meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services, **pursuant to Welf. & Inst. Code section 14197(d), as specified in BHIN 20-023 and its attachments, or in subsequent, guidance issued by the Department.**
  - 2) Comply with the timeliness standards specified in California Code of Regulations., tit. 9, section 1810.405(c) and Welf. & Inst. Code §



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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**.
- 8) ~~The timeliness standards specified in California Code of Regulations, **tit. 9**, section 1810.405 and Welf. Inst. Code § 14717.1 apply to out-of-plan services, as well as in-plan services.~~

**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 20-023 and its attachments, or in subsequent guidance issued by the Department.** ~~the network adequacy standards developed by the Department as required by departmental guidance and regulation. (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 20-023 and its attachments, or in subsequent guidance issued by the Department** in a format specified by the



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~~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).)

C. The Contractor shall submit the documentation at **the times** as specified **in BHIN 20-023 and its attachments, 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 MHP's operations that would affect the capacity and services, including changes in Contractor services, benefits, geographic service area, composition of, or payments to its provider network; or enrollment of a new population. 42 C.F.R. § 438.207(c)(3)(i)(ii)** : ~~At any time there has been a significant change, as defined by the Department, in Contractor's operations that would affect the adequacy and capacity of services, including the following:~~
  - ~~a) A decrease of 25 percent or more in services or providers available to beneficiaries;~~
  - ~~b) Changes in benefits;~~
  - ~~c) Changes in geographic service area;~~
  - d) **Changes in the** ~~Composition of or payments to Contractor's provider network; or~~

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

**f) 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 Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

**6. Choice of Provider**

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. 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 his or her

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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;
  - 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, 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. Contractor shall only use licensed, registered, or waived 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).)

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**8. Provider Certification**

- A. The Contractor shall comply with California Code of Regulations, title 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.
- 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 California Code of Regulations, title 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 California Code of Regulations, title 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

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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.
  - 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,

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as described in California Code of Regulations., title 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 California Code of Regulations., title 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.

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- 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 2 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 2 of this exhibit.
- J. On-site review is not required for hospital outpatient departments which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.
- K. On-site review is not required for primary care and psychological clinics, as defined in Health and Safety Code section 1204.1 and licensed under the Health and Safety Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license.
- L. When on-site review of an organizational provider is required, the Contractor or the Department, as applicable, shall conduct an on-site review at least once every three years. Additional certification reviews of organizational providers may be conducted by the Contractor or Department, as applicable, at its discretion, if:
  - 1) The provider makes major staffing changes.
  - 2) The provider makes organizational and/or corporate structure changes (example: conversion to non-profit status).
  - 3) The provider adds day treatment or medication support services when medications are administered or dispensed from the provider site.
  - 4) There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

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- 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.

**9. Provider Beneficiary Communications**

- A. The Contractor shall not prohibit nor otherwise restrict, a licensed, waived, or registered professional, as defined in California Code of Regulations, title 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



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- 4) The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (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 fair 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 fair hearing after the Contractor has made a determination on a beneficiary's appeal, which is adverse to the beneficiary.
  - 5) The beneficiary's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or state fair 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 fair hearing is pending if the final decision is adverse to the beneficiary.

**Exhibit A – Attachment 9 A1  
DOCUMENTATION REQUIREMENTS**

**1. Documentation Standards**

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

A. Assessment

- 1) The Contractor shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed. For children or certain other beneficiaries unable to provide a history, this information may be obtained from the parents/care-givers, etc.
  - a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
  - b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
  - c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

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- d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
- g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
- i) A mental status examination;
- j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,
- k) Additional clarifying formulation information, as needed.

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DOCUMENTATION REQUIREMENTS**

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

**B. Client Plans**

- 1) The Contractor shall ensure that Client Plans:
- a) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
  - b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;
  - c) Have a proposed frequency and duration of intervention(s);
  - d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b)); have interventions that are consistent with the client plan goal;
  - e) Be consistent with the qualifying diagnoses;
  - f) Be signed (or electronic equivalent) by:
    - i. The person providing the service(s), or,
    - ii. A person representing a team or program providing services, or
    - iii. A person representing the Contractor providing services; or
    - iv. By one of the following as a co-signer, if the client plan is used to establish that services are provided under the

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DOCUMENTATION REQUIREMENTS**

direction of an approved category of staff, and if the signing staff is not of the approved category:

- a) A physician,
  - b) A licensed/waivered psychologist,
  - c) A licensed/registered/waivered social worker,
  - d) A licensed/registered/waivered marriage and family therapist, or
  - e) A registered nurse, including but not limited to nurse practitioners, and clinical nurse specialists.
- g) Include documentation of the beneficiary's participation in and agreement with the client plan, as described in Cal. Code Regs., tit. 9, § 1810.440(c)(2)(A)(B).
- i. Examples of acceptable documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary signature on the plan, or a description of the beneficiary's participation and agreement in the client record;
  - ii. The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:
    - a) The beneficiary is expected to be in long term treatment as determined by the MHP and,
    - b) The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service;

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- iii. When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.
- 2) There shall be documentation in the client plan that a copy of the client plan was offered to the beneficiary.
- 3) The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition.

C. Progress Notes

- 1) The Contractor shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:
  - a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
  - b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
  - c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;
  - d) The date the services were provided;
  - e) Documentation of referrals to community resources and other agencies, when appropriate;
  - f) Documentation of follow-up care, or as appropriate, a discharge summary; and

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DOCUMENTATION REQUIREMENTS**

- g) The amount of time taken to provide services; and
  - h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.
- 2) Timeliness/Frequency of Progress Notes. Progress notes shall be documented at the frequency by type of service indicated below:
- a) Every Service Contact:
    - i. Mental Health Services;
    - ii. Medication Support Services;
    - iii. Crisis Intervention;
    - iv. Targeted Case Management;
  - b) Daily:
    - i. Crisis Residential;
    - ii. Crisis Stabilization (1x/23hr);
    - iii. Day Treatment Intensive; and
  - c) Weekly:
    - i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
    - ii. Day Rehabilitation;
    - iii. Adult Residential.

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DOCUMENTATION REQUIREMENTS**

D. Other

- 1) All entries to the beneficiary record shall be legible.
- 2) All entries in the beneficiary record shall include:
  - a) The date of service;
  - b) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.
  - c) The date the documentation was entered in the beneficiary record.
- 3) The Contractor shall have a written definition of what constitutes a long term care beneficiary.
- 4) Contractor shall require providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the beneficiary.



**Exhibit A – Attachment 10 A1  
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 his or her 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).)

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COORDINATION AND CONTINUITY OF CARE**

- B. 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 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. (Cal. Code Regs., tit. 9, § 1810.370.)
- C. 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** ~~and complies with the Department's transition of care policy.~~ (42 C.F.R. § 438.62(b)(1)-(2).)

**Exhibit A – Attachment 11 A1  
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;

**Exhibit A – Attachment 11 A1  
INFORMATION REQUIREMENTS**

- 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

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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, ~~within 15 calendar days after receipt or issuance of the termination notice~~, 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, ~~including large print~~, upon request of the potential beneficiary or beneficiary at no cost. ~~Large print means printed in a font size no smaller than 18 point.~~ **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 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 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

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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).)

~~2) The Contractor shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (42 C.F.R. § 438.10(d)(2).)~~

~~3) The Contractor shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit. (42 C.F.R. § 438.10(d)(3).)~~

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

5) 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).) 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** is available **free of charge** and how to access **these**

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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 all 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,**

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**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:
  - 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).)



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- 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 fair 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;

**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.**

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- 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 fair 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 fair 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 fair 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 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:

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- 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 California Code of Regulations, title 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.

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**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, waived, or registered mental health provider employed by the Contractor, each provider organization or individual practitioner contracting with the Contractor, and each licensed, waived, 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, ~~and whether the provider has completed cultural competence training.~~ (42 C.F.R. § 438.10(h)(1)(vii).)
  - 4) Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 C.F.R. § 438.10(h)(1)(viii).)
  - 5) A means to identify which providers are accepting new beneficiaries. (42 C.F.R. § 438.10(h)(1)(vi).)

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- 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. **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).)
- 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

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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, California Code of Regulations, title 9, sections 862 through 868, and 42 Code of Federal Regulations section 438.100. The Contractor shall ensure that its subcontractors comply with all applicable patients' rights laws and regulations.
- B. The Contractor shall have written policies regarding the 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 his or her 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 his or her health care, including the right to refuse treatment. (42 C.F.R. § 438.100(b)(2)(iv).)
  - 5) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. (42 C.F.R. § 438.100(b)(2)(v).)
  - 6) Request and receive a copy of his or her 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.)

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- 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 his or her 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 fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of adverse benefit determination. For the purposes of this Section, a Contractor provider site means



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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 fair 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 fair 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-**

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**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 fair 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

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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).)

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- 16) The Contractor shall provide the beneficiary and his or her 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 his or her 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

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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).)

- 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).)

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- 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. Contractor's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees 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 he or she could not be contacted. (Cal. Code Regs., tit. 9, § 1850.206(c).)

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- 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:**

- 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.**



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- 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).);



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- 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** ~~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); 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. Contractor's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees with the Contractor's decision. 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 his or her 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 his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions. For

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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, his or her 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 his or her 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 fair hearing and the procedure for requesting a fair hearing, if the beneficiary has not already requested a fair 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 fair 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 he or she may be liable for the cost of any continued benefits if the Contractor's adverse

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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:
- 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

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extend this timeframe by up to 14 calendar days if the beneficiary requests an extension, or the Contractor **demonstrates** ~~determines~~, **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 his or her 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 his or her 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 he or she disagrees with the decision. (42 C.F.R. § 438.410(c)(2); 42 C.F.R. §

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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 Fair Hearing**

State “Fair Hearing” means the State hearing provided to beneficiaries pursuant to sections 50951 and 50953 of Title 22 of the California Code of Regulations ~~section~~ and section 1810.216.6 of Title 9 of the California Code of Regulations 1810.216.6.:

A. If a beneficiary requests a State Fair Hearing, the Department shall grant the request. (42 C.F.R. § 431.220(a)(5).) The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or Notice of 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 Fair 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 fair 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 Fair 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 Fair Hearing**

“Expedited Fair Hearing” means a fair hearing, used when the Contractor determines, or the beneficiary or the beneficiary’s provider certifies that following the 90 day timeframe for a fair hearing as established in 42 C.F.R. § 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to

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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 fair 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).)
  - 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 fair hearing is pending, the benefits must be continued until the beneficiary withdraws the appeal or request for state

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fair hearing, the beneficiary does not request a state fair 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 fair 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 fair hearing was pending if the final resolution of the appeal or state fair 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 fair 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).)



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- 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).)
- 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 California Code of Regulations, 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 California Code of Regulations, tit. 9, 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 Contractor payment authorization for a specialty mental health service that



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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).)
- 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 medical necessity criteria in sections 1830.205(b)(1),(b)(2),(b)(3)(C), or 1830.210(a) of Title 9 of the California Code of Regulations 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).)

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- 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.

**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 medical necessity criteria, 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).)

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- 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 fair 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 fair hearing or an expedited fair hearing, including:
    - a) The method by which a hearing may be obtained; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(A).)
    - b) A statement that the 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 fair hearing is requested; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(C).) and
    - d) The time limits for requesting a fair hearing or an expedited fair 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

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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).)
- 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,

**Exhibit A – Attachment 12 A1  
BENEFICIARY PROBLEM RESOLUTION**

- 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 his or her 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 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

**Exhibit A – Attachment 12 A1  
BENEFICIARY PROBLEM RESOLUTION**

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 he or she is ineligible for further services; (42 C.F.R. § 431.213(c).)
- 4) The beneficiary's whereabouts are unknown and mail directed to him or her 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).)
- 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 NF 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).)

**Exhibit A – Attachment 13 A1  
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



**Exhibit A – Attachment 13 A1  
PROGRAM INTEGRITY**

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).)



**Exhibit A – Attachment 13 A1  
PROGRAM INTEGRITY**

**4. Fraud Reporting Requirements**

- A. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to the Department about the following:
- 1) Any potential fraud, waste, or abuse. (42 C.F.R. §438.608(a), (a)(7).)
  - 2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. §438.608(a), (a)(2).)
  - 3) Information about changes in a 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).)

**Exhibit A – Attachment 13 A1  
PROGRAM INTEGRITY**

- 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).)

**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. §

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PROGRAM INTEGRITY**

455.101. For purposes of this disclosure, Contractor may use the business address for any member of its Board of Supervisors.

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

**Exhibit A – Attachment 13 A1  
PROGRAM INTEGRITY**

- 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, 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 – Contractor must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.
- 1) The following information must be disclosed:
    - a) The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
    - b) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

**Exhibit A – Attachment 13 A1  
PROGRAM INTEGRITY**

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

**C. Disclosures Related to Persons Convicted of Crimes**

- 1) 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 A1 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

**Exhibit A – Attachment 14 A1  
REPORTING REQUIREMENTS**

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.)

- 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

**Exhibit A – Attachment 14 A1  
REPORTING REQUIREMENTS**

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

- 1) Enrollment and disenrollment data;
- 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.

**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 B A1**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

**1. Payment Provisions**

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

**2. Budget Contingency Clause**

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

**A. Federal Budget**

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

**B. Delayed Federal Funding**

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

**3. Federal Financial Participation**

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

**Exhibit B A1**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

**4. Audits and Recovery of Overpayments**

- A. Pursuant to Welf. & Inst. Code § 14707, in the case of federal audit exceptions, the Department will follow federal audit appeal processes unless the Department, in consultation with the California Mental Health Director's Association, determines that those appeals are not cost beneficial.
- 1) Whenever there is a final federal audit exception against the State resulting from a claim for federal funds for an expenditure by individual counties that is not federally allowable, the department may offset federal reimbursement and request the Controller's office to offset the distribution of funds to the Contractor from the Mental Health Subaccount, the Mental Health Equity Subaccount and the Vehicle License Collection Account of the Local Revenue Fund; funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011; and any other mental health realignment funds from which the Controller makes distributions to the counties by the amount of the exception. The Department shall provide evidence to the Controller that the county had been notified of the amount of the audit exception no less than 30 days before the offset is to occur.
  - 2) The Department will involve the Contractor in developing responses to any draft federal audit reports that directly impact the county.
- B. Pursuant to Welf. & Inst. Code § 14718(b)(2), the Department may offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the Contractor.
- 1) The Department may offset the amount of any state disallowance, audit exception, or overpayment for fiscal years through and including 2010-11 against subsequent claims from the Contractor.
  - 2) Offsets may be done at any time, after the department has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the mental health plan.
  - 3) The maximum withheld amount shall be 25 percent of each payment as long as the Department is able to comply with the federal requirements for repayment of FFP pursuant 42 United States Code (U.S.C.) §1396b(d)(2)).

**Exhibit B A1**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

The Department may increase the maximum amount when necessary for compliance with federal laws and regulations.

- C. Pursuant to the Welf. & Inst. Code § 14170, cost reports submitted to the Department are subject to audit in the manner and form prescribed by the Department. The year-end cost report shall include both Contractor's costs and the costs of its subcontractors, if any. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. In accordance with the Welf. & Inst. Code § 14170, any audit of Contractor's cost report shall occur within three years of the date of receipt by the Department of the final cost report with signed certification by the Contractor's Mental Health Director and one of the following: (1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county auditor controller, or equivalent. Both signatures are required before the cost report shall be considered final. For purposes of this section, the cost report shall be considered audited once the Department has informed the Contractor of its intent to disallow costs on the cost report, or once the Department has informed the Contractor of its intent to close the audit without disallowances.
- D. If the adjustments result in the Department owing FFP to the Contractor, the Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority.

**5. Claims Adjudication Process**

- A. In accordance with the Welf. & Inst. Code §14705(c), claims for federal funds in reimbursement for services shall comply with eligibility and service requirements under applicable federal and state law.
- B. The Contractor shall certify each claim submitted to the Department in accordance with Cal. Code Regs., tit. 9, § 1840.112 and 42 C.F.R. § 433.51, at the time the claims are submitted to the Department. The Contractor's Chief Financial Officer or his or her equivalent, or an individual with authority delegated by the county auditor-controller, shall sign the certification, declaring, under penalty of perjury, that the Contractor has incurred an expenditure to cover the services included in the claims to satisfy the requirements for FFP. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification, declaring, under penalty of perjury that, to the best of his or her knowledge and belief, the claim is in all respects true, correct, and in accordance with the law and meets the requirements of Cal. Code Regs., tit. 9, § 1840.112(b). The Contractor shall have mechanisms that support the Mental

**Exhibit B A1**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

Health Director's certification, including the certification that the services for which claims were submitted were actually provided to the beneficiary. If the Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 C.F.R. § 438.604.

- C. Claims not meeting federal and/or state requirements shall be returned to Contractor as not approved for payment, along with a reason for denial. Claims meeting all Health Insurance Portability and Accountability Act (HIPAA) transaction requirements and any other applicable federal or state privacy laws or regulations and certified by the Contractor in accordance with Cal. Code Regs., tit. 9, §1840.112, shall be processed for adjudication.
- D. Good cause justification for late claim submission is governed by applicable federal and state laws and regulations and is subject to approval by the Department.
- E. In the event that the Department or the Contractor determines that changes requiring a change in the Contractor's or Department's obligation must be made relating to either the Department's or the Contractor's claims submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated requirements and impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.
- F. The Contractor shall comply with Cal. Code Regs., tit. 9, § 1840.304, when submitting claims for FFP for services billed by individual or group providers. The Contractor shall submit service codes from the Health Care Procedure Coding System (HCPCS) published in the most current Mental Health Medi-Cal billing manual.

**6. Payment Data Certification**

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

**7. System Changes**

In the event changes in federal or state law or regulations, including court decisions and interpretations, necessitate a change in either the fiscal or program obligations or

**Exhibit B A1**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

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

**8. Administrative Reimbursement**

- A. The Contractor may submit claims for reimbursement of Medical Administrative Activities (MAA) pursuant to Welf. & Inst. Code § 14132.47. The Contractor shall not submit claims for MAA unless it has submitted a claiming plan to the Department which was approved by the Department and is effective during the quarter in which the costs being claimed were incurred. In addition, the Contractor shall not submit claims for reimbursements of MAA that are not consistent with the Contractor's approved MAA claiming plan. The Contractor shall not use the relative value methodology to report its MAA costs on the year-end cost report. Rather, the Contractor shall calculate and report MAA units on the cost report by multiplying the amount of time (minutes, hours, etc.) spent on MAA activities by the salary plus benefits of the staff performing the activity and then allocating indirect administrative and other appropriately allocated costs.
- B. Pursuant to the Welf. & Inst. Code § 14711(c), administrative costs shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medicaid state plans and waivers and shall be limited to 15 percent of the total actual cost of direct client services. The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative costs.

**9. Notification of Request for Contract Amendment**

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

**Exhibit E A1  
ADDITIONAL PROVISIONS**

**1. Additional Incorporated Exhibits**

A. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit A, Attachment 9	Documentation Requirements	7 page(s)
2) Exhibit A, Attachment 10	Coordination And Continuity Of Care	2 page(s)
3) Exhibit A, Attachment 11	Information Requirements	13 pages
4) Exhibit A, Attachment 12	Beneficiary Problem Resolution	23 pages
5) Exhibit A, Attachment 13	Program Integrity	7 pages
6) Exhibit A, Attachment 14	Reporting Requirements	3 pages
7) Exhibit B	Budget Detail And Payment Provisions	5 pages
8) Exhibit C *	General Terms And Conditions	<a href="#">GTC 04/2017</a>
9) Exhibit D (F)	Special Terms And Conditions (Attached hereto as part of this agreement) (Notwithstanding Provisions 2, 3, 4, 6 ,8, 12, 14, 22, 25, 29, and 30 which do not apply to this agreement.)	27 pages
10) Exhibit E	Additional Provisions (Program Terms And Conditions)	17 pages
11) Exhibit E, Attachment 1	Definitions	5 pages
12) Exhibit E, Attachment 2	Service Definitions	6 pages
13) Exhibit F	HIPAA Business Associate Addendum	27 pages
14) Exhibit F, Attachment B	Information Security Exchange Agreement between the Social Security Administration (SSA) and the California Department of Health Care Services (DHCS)	101 pages

**2. Amendment Process**

Should either party, during the term of this Contract, desire a change or amendment to the terms of this Contract, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether

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the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

**3. Cancellation/Termination**

A. General Provisions

- 1) As required by, if the Contractor decides not to contract with the Department, does not renew its contract, or is unable to meet the standards set by the Department, the Contractor agrees to inform the Department of this decision in writing. (Welf. & Inst. Code § 14712(c)(1).)
- 2) If the Contractor is unwilling to contract for the delivery of specialty mental health services or if the Department or Contractor determines that the Contractor is unable to adequately provide specialty mental health services or that the Contractor does not meet the standards the Department deems necessary for a mental health plan, the Department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries. (Welf. & Inst. Code § 147122(c)(2), (3).)
- 3) The Department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the Department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the Department. The Contractor may not subsequently contract to provide specialty mental health services unless the Department elects to contract with the Contractor. (Welf. & Inst. Code § 147122(c)(4).)
- 4) If the Contractor does not contract with the Department to provide specialty mental health services, the Department will work with the Department of Finance and the Controller to obtain funds from the Contractor in accordance with Government (Govt.) Code 30027.10. (Welf. & Inst. Code § 147122(d).)



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**B. Contract Renewal**

- 1) This contract may be renewed if the Contractor continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. (42 C.F.R. § 438.708; Welf. & Inst. Code § 14714(b)(1).) The Department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract. (Welf. & Inst. Code § 14714(b)(1).)
- 2) In the event the contract is not renewed based on the reasons specified in (1), the Department will notify the Department of Finance, the fiscal and policy committees of the Legislature, and the Controller of the amounts to be sequestered from the Mental Health Subaccount, the Mental Health Equity Account, and the Vehicle License Fee Collection Account of the Local Revenue Fund and the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and the Controller will sequester those funds in the Behavioral Health Subaccount pursuant to Govt. Code § 30027.10. Upon this sequestration, the Department will use the funds in accordance with Govt. Code § 30027.10. (Welf. & Inst. Code § 14714(b)(3).)

**C. Contract Amendment Negotiations**

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



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change mutually agreed to by the parties on the condition that the amendment is approved by the Department of General Services, if necessary.

**D. Contract Termination**

The Department or the Contractor may terminate this contract in accordance with, and within the given timeframes provided in California Code of Regulations, title 9, section 1810.323.

- 1) DHCS reserves the right to cancel or terminate this Contract immediately for cause.
- 2) The term "for cause" shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Contract.
- 3) Contract termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor. The notice shall identify any final performance, invoicing or payment requirements.
- 4) Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel, or if cancellation is not possible reduce, subsequent contract costs.
- 5) In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Contract and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.
- 6) The Department will immediately terminate this Contract if the Department finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons will be subject to reasonable notice to the Contractor of the Department's intent to terminate, as well as notification to affected beneficiaries. (Welf. & Inst. Code § 14714(d).)

**E. Termination of Obligations**

- 1) All obligations to provide covered services under this contract shall automatically terminate on the effective date of any termination of

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this contract. The Contractor shall be responsible for providing covered services to beneficiaries until the termination or expiration of the contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to beneficiaries prior to such expiration or termination.

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

**F. Contract Disputes**

Should a dispute arise between the Contractor and the Department relating to performance under this contract, other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, California Code of Regulations, title 9, or the processes governing the audit appeals process in Chapter 9 of Division 1, California Code of Regulations, title 9 the Contractor shall follow the Dispute Resolution Process outlined in provision number 15 of Exhibit D(F) which is attached hereto as part of this contract.

**4. Fulfillment of Obligation**

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

**5. Additional Provisions**

**A. Inspection Rights/Record Keeping Requirements**

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

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- 2) The Contractor, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. Contractor shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.
- 3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract, including beneficiary grievance and appeal records identified in Attachment 12, Section 2 and the data, information and documentation specified in 42 Code of Federal Regulations parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (42 C.F.R. § 438.3(u); See also § 438.3(h).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's

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performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

**B. Notices**

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

Department of Health Care Services  
**Medi-Cal Behavioral Mental Health**  
**Services Division**  
15001 Capitol Avenue, MS 2702  
P.O. Box 997413  
Sacramento, CA 95899-7413 **95814**

San Francisco Community Behavioral  
Health Services  
1380 Howard St.  
San Francisco, CA 94103

**C. Nondiscrimination**

- 1) Consistent with the requirements of applicable federal law, such as 42 Code of Federal Regulations, part 438.3(d)(3) and (4), and state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect ~~on the basis of~~ **any ground protected under federal or state law, including sex,** race, color, gender, gender identity, religion, marital status, national origin, **ethnic group identification, ancestry,** age, sexual orientation, **medical condition, genetic information,** or mental or physical handicap or disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(~~3-4~~); 45 C.F.R. § 92.28(a)(1); Gov. Code § 11135(a); Welf. & Inst. Code § 14727(a)(3).)
- 2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended (**codified at 29 U.S.C. § 794**), ~~pertaining to the prohibition of~~ **exclusion, denial of benefits, and** discrimination against qualified ~~handicapped persons~~ **individuals with a disability** in ~~all~~ **any** federally assisted programs

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or activities, **and shall comply with the implementing regulations** as detailed in regulations **Parts 84 and 85 of Title 45 of the C.F.R., as applicable** signed by the Secretary of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977.

- 3) The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.
- 4) Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to California Code of Regulations., title 9, sections 1820.205, 1830.205 and/or 1830.210, prior to providing covered services to a beneficiary.

**D. Relationship of the Parties**

The Department and the Contractor are, and shall at all times be deemed to be, independent agencies. Each party to this contract shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this contract. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department and its agents and employees shall not be entitled to any rights or privileges of the Contractor's employees and shall not be considered in any manner to be Contractor employees. The Contractor and its agents and employees, shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

**E. Waiver of Default**

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

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**6. Duties of the State**

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

A. Payment for Services

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

B. Reviews

The Department shall conduct reviews of access to and quality of care in Contractor's county at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, pursuant to California Code of Regulations, title 9, sections 1810.380 and 1810.385. The Department shall also arrange for an annual external quality review of the Contractor as required by 42 Code of Federal Regulations, part 438.350 and California Code of Regulations, title 9, section 1810.380(a)(7).

C. Monitoring for Compliance

When monitoring activities identify areas of non-compliance, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action. (Cal. Code Reg., tit. 9, § 1810.380.) Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to Cal. Code Reg., tit. 9, § 1810.385.

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

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- E. If the Contractor has not previously implemented a Mental Health Plan or Contractor will provide or arrange for the provision of covered benefits to new eligibility groups, then the Contractor shall develop an Implementation Plan (as defined in Cal. Code Regs., tit. 9, § 1810.221) that is consistent with the readiness review requirements set forth in 42 Code of Federal Regulations, part 438.66(d)(4), and the requirements of Cal. Code Regs., tit. 9, § 1810.310 (a). (See 42 C.F.R. § 438.66(d)(1), (4).) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to the Contractor within 60 days of the receipt of the Implementation Plan. (Cal. Code Regs., tit. 9, § 1810.310(b).) A Contractor shall submit proposed changes to its approved Implementation Plan in writing to the Department for review. A Contractor shall submit proposed changes in the policies, processes or procedures that would modify the Contractor's current Implementation Plan prior to implementing the proposed changes.(See Cal. Code Regs., tit. 9, § 1810.310 (b)-(c)).
- F. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Cal. Code Regs., tit. 9, § 1810.410. The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for the disapproval, to the Contractor within 60 calendar days after receipt of the plan from the Contractor. If the Department fails to provide a Notice of Approval or Disapproval, the Contractor may implement the plan 60 calendar days from its submission to the Department.
- G. Certification of Organizational Provider Sites Owned or Operated by the Contractor
- 1) The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with California Code of Regulations., tit. 9, section 1810.435, and the requirements specified in Exhibit A, Attachment 3, Section 6 of this contract. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every three years after that date, unless the Department determines an earlier date is necessary. The on-site review required by Cal. Code Regs., tit. 9, § 1810.435(e), shall be conducted of any site owned, leased, or operated by the Contractor and used for to deliver covered services



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to beneficiaries, except that on-site review is not required for public school or satellite sites.

- 2) The Department may allow the Contractor to begin delivering covered services to beneficiaries at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained, whichever date is latest.
- 3) The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational and has all required fire clearances.
- 4) Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of FFP by the Contractor and the Department's tracking of that information.

H. Excluded Providers

- 1) If the Department learns that the Contractor has a prohibited affiliation, as described in Attachment 1, Section 2, the Department:
  - a) Must notify the Secretary of the noncompliance.
  - b) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
  - c) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.



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

I. Sanctions

The Department shall conduct oversight and impose sanctions on the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations, in accordance with Welf. & Inst. Code § ~~14197.714712(e)~~ **14197.714712(e)** and Cal. Code Regs., tit. 9, §§ 1810.380 and 1810.385.

J. Notification

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

K. Performance Measurement

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

**7. State and Federal Law Governing this Contract**

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

- B. Contractor agrees to comply with all applicable federal and state law, including the applicable sections of the state plan and waiver, including but not limited to the statutes and regulations incorporated by reference below in Sections **D, G, and H, C, E, and F, and applicable sections of the state plan and waiver** in its provision of services as the Mental Health Plan. Contractor agrees to comply with any changes to these statutes and regulations that may occur during the contract period and any new applicable statutes or regulations. These obligations shall not apply without the need for a Contract amendment(s). To the extent there is a conflict between federal or state law or regulation and a provision in this

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contract, Contractor shall comply with the federal or state law or regulation and the conflicting Contract provision shall no longer be in effect.

- C. Contractor agrees to comply with all existing policy letters issued by the Department. All policy letters issued by the Department subsequent to the effective date of this Contract shall provide clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to State or federal statutes or regulations, or pursuant to judicial interpretation.
- D. Federal law:
- 1) Title 42 United States Code, to the extent that these requirements are applicable;
  - 2) 42 C.F.R. to the extent that these requirements are applicable;
  - 3) 42 C.F.R. Part 438, Medicaid Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHPs), except for the provisions listed in paragraph D and E, below.
  - 4) 42 C.F.R. § 455 to the extent that these requirements are applicable;
  - 5) **45 C.F.R. § 92.1 et seq. to the extent these requirements are applicable;**
  - 6) Title VI of the Civil Rights Act of 1964;
  - 7) Title IX of the Education Amendments of 1972;
  - 8) Age Discrimination Act of 1975;
  - 9) Rehabilitation Act of 1973;
  - 10) Americans with Disabilities Act;
  - 11) Section 1557 of the Patient Protection and Affordable Care Act;
  - 12) Deficit Reduction Act of 2005;

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- 13) Balanced Budget Act of 1997;
- 14) The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act, which requires that all contracts and subcontracts in excess of \$2000 for construction or repair awarded by the Contractor and its subcontractors shall include a provision for compliance with the Copeland Anti-Kickback Act.
- 15) The Contractor shall comply with the provisions of the Davis-Bacon Act, as amended, which provides that, when required by Federal Medicaid program legislation, all construction contracts awarded by the Contractor and its subcontractors of more than \$2,000 shall include a provision for compliance with the Davis-Bacon Act as supplemented by Department of Labor regulations.
- 16) The Contractor shall comply with the provisions of the Contract Work Hours and Safety Standards Act, as applicable, which requires that all subcontracts awarded by the Contractor in excess of \$2,000 for construction and in excess of \$2,500 for other subcontracts that involve the employment of mechanics or laborers shall include a provision for compliance with the Contract Work Hours and Safety Standards Act.
- 17) Any applicable federal and state laws that pertain to beneficiary rights.
- 18) **Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS must adjust payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the**

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**work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.**

- E. The following sections of 42 Code of Federal Regulations, part 438 are inapplicable to this Contract:
- 1) §438.3(b) Standard Contract Provisions – Entities eligible for comprehensive risk contracts
  - 2) §438.3(c) Standard Contract Provisions - Payment
  - 3) §438.3(g) Standard Contract Provisions - Provider preventable conditions
  - 4) §438.3(o) Standard Contract Provisions - LTSS contract requirements
  - 5) §438.3(p) Standard Contract Provisions – Special rules for HIOs
  - 6) §438.3(s) Standard Contract Provisions – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs
  - 7) §438.4 Actuarial Soundness
  - 8) §438.5 Rate Development Standards
  - 9) §438.6 Special Contract Provisions Related to Payment
  - 10) §438.7 Rate Certification Submission
  - 11) §438.8 Medical Loss Ratio Standards
  - 12) §438.9 Provisions that Apply to Non-emergency Medical Transportation

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- 13) §438.50 State Plan Requirements
  - 14) §438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities
  - 15) §438.56 Disenrollment: requirements and limitations
  - 16) §438.70 Stakeholder engagement when LTSS is delivered through a managed care program
  - 17) 438.74 State Oversight of the Minimum MLR Requirements
  - 18) §438.104 Marketing
  - 19) **§438.106 Liability for Payment**
  - 20) **§438.108 Cost Sharing**
  - 21) §438.110 Member advisory committee
  - 22) §438.114 Emergency and Post-Stabilization
  - 23) §438.362 Exemption from External Quality Review
  - 24) §438.700-730 Basis for Imposition of Sanctions
  - 25) §438.802 Basic Requirements
  - 26) §438.810 Expenditures for Enrollment Broker Services
  - 27) §438.816 Expenditures for the beneficiary support system for enrollees using LTSS
- F. Specific provisions of 42 Code of Federal Regulations, part 438 relating to the following subjects are inapplicable to this Contract:
- 1) Long Terms Services and Supports
  - 2) Managed Long Terms Services and Supports
  - 3) Actuarially Sound Capitation Rates

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- 4) Medical Loss Ratio
  - 5) Religious or Moral Objections to Delivering Services
  - 6) Family Planning Services
  - 7) Drug Formularies and Covered Outpatient Drugs
- G. Pursuant to Welf. & Inst. Code section 14704, a regulation or order concerning Medi-Cal specialty mental health services adopted by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000), as in effect preceding the effective date of this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by DHCS, or until it expires by its own terms.
- H. State Law:
- 1) Division 5, Welf. & Inst. Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 2) Welf. & Inst. Code §§ 14680-14685.1
  - 3) Welf. & Inst. Code §§ 14700-14727~~6~~
  - 4) Chapter 7, Part 3, Division 9, Welf. & Inst. Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 5) Cal. Code Regs., tit. 9, § 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services
  - 6) Cal. Code Regs., tit. 22, §§ 50951 and 50953
  - 7) Cal. Code Regs., tit. 22, §§ 51014.1 and 51014.2

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

1. The following definitions and the definitions contained in California Code of Regulations., title 9, sections 1810.100-1850.535 shall apply in this contract. If there is a conflict between the following definitions and the definitions in California Code of Regulations., title 9, sections 1810.100-1850.535, the definitions below will apply.
  - A. “Advance Directives” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the healthcare when the individual is incapacitated.
  - B. “Abuse” means, as the term described in, provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)
  - C. “Appeal” means a review by the Contractor of an adverse benefit determination.
  - D. “Beneficiary” means a Medi-Cal recipient who is currently receiving services from the Contractor.
  - E. "Contractor" means San Francisco Community Behavioral Health Services.
  - F. "Covered Specialty Mental Health Services" are defined in Exhibit E, Attachment 2.
  - G. "Department" means the California Department of Health Care Services (DHCS).
  - H. “Director” means the Director of DHCS.
  - I. **“Discrimination Grievance” means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.**

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DEFINITIONS**

- J. “Emergency” means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (Health & Safety Code § 1797.07).
- K. “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes an act that constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)
- L. “Grievance” means an expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights regardless of whether remedial action is requested. Grievance includes a beneficiary’s right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400)
- M. “Habilitative services and devices” help a person keep, learn, or improve skills and functioning for daily living. (45 C.F.R. § 156.115(a)(5)(i))
- N. "HHS" means the United States Department of Health and Human Service
- ~~O. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association, or the American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)~~
- P. **“Managed Care Organization” (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. Part 438, and is: 1) a Federally qualified HMO that meets the advance directives requirements of Subpart I of Part 489 of 42 C.F.R.; or, 2) any public or private entity that meets the advance directive requirements and is determined by the Secretary of Health and Human Services to also meet the following conditions: i) makes the services that it provides to its Medicaid beneficiaries as accessible (in terms of timeliness, amount, duration, and scope) as those**



**Exhibit E – Attachment 1 A1  
DEFINITIONS**

**services are to other Medicaid beneficiaries within the area served by the entity, ii) meet the solvency standards of 42 C.F.R. 438.116. (42 C.F.R. § 438.2)**

- Q. A “Network Provider” means any provider, group of providers, or entity that has a network provider agreement with a Mental Health Plan, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department’s contract with a Mental Health Plan. A network provider is not a subcontractor by virtue of the network provider agreement. (42 C.F.R. § 438.2)
- R. “Out-of-network provider” means a provider or group of providers that does not have a network provider agreement with a Mental Health Plan, or with a subcontractor. (A provider may be “out of network” for one Mental Health Plan, but in the network of another Mental Health Plan.)
- S. “Out-of-plan provider” has the same meaning as out-of-network provider.
- T. **“Overpayment” means any payment made to a network provider by a Mental Health Plan to which the network provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)**
- U. “Provider” means a person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.
- ~~V. “Overpayment” means any payment made to a network provider by a Mental Health Plan to which the provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)~~

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

- W. “Physician Incentive Plans” mean any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.
- X. “PIHP” means Prepaid Inpatient Health Plan. . A Prepaid Inpatient Health Plan is an entity that:
- 1) Provides medical services to beneficiaries under contract with the Department of Health Care Services, and on the basis of prepaid capitation payments, or other payment arrangement that does not use state plan rates;
  - 2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and
  - 3) Does not have a comprehensive risk contract. (42 C.F.R. § 438.2)
- Y. "Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries. (California's Medicaid State Plan, State Plan Amendment 10-016, Attachment 3.1-A, Supplement 3, p. 2a.)
- Z. “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.
- AA. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate**

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

**Medical Education, the American Medical Association, or the  
American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)**

- BB. "Subcontract" means an agreement entered into by the Contractor with any of the following:
- 1) Any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this contract.
  - 2) "Subcontractor" means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. Notwithstanding the foregoing, for purposes of Exhibit D(F) the term "subcontractor" shall include network providers.

**Exhibit E – Attachment 2 A1  
SERVICE DEFINITIONS**

1. The Contractor shall provide, or arrange and pay for, the following medically necessary covered specialty mental health services to beneficiaries of San Francisco County. Services shall be provided based on medical necessity criteria, in accordance with an individualized Client Plan, and approved and authorized according to State of California requirements. Services include:
  - A. Mental Health Services Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:
    - 1) Assessment - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.
    - 2) Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.
    - 3) Therapy - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.
    - 4) Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.
    - 5) Collateral - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited

**Exhibit E – Attachment 2 A1**  
**SERVICE DEFINITIONS**

to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

- B. Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.
- C. Day Treatment Intensive are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- D. Day Rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

**Exhibit E – Attachment 2 A1**  
**SERVICE DEFINITIONS**

- E. Crisis Intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.
- F. Crisis Stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- G. Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- H. Crisis Residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.
- I. Psychiatric Health Facility Services—A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated

**Exhibit E – Attachment 2 A1  
SERVICE DEFINITIONS**

general acute care hospital or in outpatient settings. These services are separate from those categorized as “Psychiatric Inpatient Hospital”.

- J. Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the **Integrated** Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a **child** youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:
- 1) Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth-**child** driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
  - 2) Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
  - 3) Supports the parent/caregiver in meeting their child/youth’s needs;
  - 4) Helps establish the CFT and provides ongoing support; and
  - 5) Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community
- K. Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth’s functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth’s family’s ability to help the



**Exhibit E – Attachment 2 A1**  
**SERVICE DEFINITIONS**

child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the **Integrated** Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

- L. Therapeutic Behavioral Services (TBS) are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.
- M. Therapeutic Foster Care (TFC) Services model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized **specialty mental health services** SMHS activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma informed interventions that are medically necessary for the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain **specialty mental health services** SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).
- N. ~~Psychiatric Inpatient Hospital~~ Psychiatric Inpatient Hospital Services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the



**Exhibit E – Attachment 2 A1**  
**SERVICE DEFINITIONS**

hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

- O. ~~Targeted Case Management~~ Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

# Contractor Certification Clauses

CCC 04/2017

## CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
San Francisco Community Behavioral Health Service	94-6000417

By (Authorized Signature)

Printed Name and Title of Person Signing

Date Executed	Executed in the County of
	San Francisco

## CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

- 1) the dangers of drug abuse in the workplace;
- 2) the person's or organization's policy of maintaining a drug-free workplace;
- 3) any available counseling, rehabilitation and employee assistance programs; and,
- 4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

- 1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES \$50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at [www.dir.ca.gov](http://www.dir.ca.gov), and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably

required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

## **DOING BUSINESS WITH THE STATE OF CALIFORNIA**

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

REGISTRATION NUMBER	AGREEMENT NUMBER <b>17-94609</b>
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- This Agreement is entered into between the State Agency and the Contractor named below:  



STATE AGENCY'S NAME <b>Department of Health Care Services</b>	(Also known as DHCS, CDHS, DHS or the State)
CONTRACTOR'S NAME <b>San Francisco Community Behavioral Health Services</b>	(Also referred to as Contractor)
- The term of this Agreement is: **July 1, 2017**  
**through June 30, 2022**
- The maximum amount of this Agreement is: **\$ 0**  
**Zero dollars**
- The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope Of Work	2 pages
Attachment 1 Organization And Administration	6 pages
Attachment 2 Scope Of Services	9 pages
Attachment 3 Financial Requirements	6 pages
Attachment 4 Management Information Systems	2 pages
Attachment 5 Quality Improvement System	6 pages
Attachment 6 Utilization Management Program	3 pages
Attachment 7 Access And Availability Of Services	4 pages
Attachment 8 Provider Network	11 pages

See Exhibit E, Provision 1 for additional incorporated exhibits.

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

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

<b>CONTRACTOR</b>		<b>California Department of General Services Use Only</b>
CONTRACTOR'S NAME (if other than an individual, state whether a corporation, partnership, etc.) <b>San Francisco Community Behavioral Health Services</b>		
BY (Authorized Signature) 	DATE SIGNED (Do not type)	
PRINTED NAME AND TITLE OF PERSON SIGNING <b>Kavoos Ghane Bassiri, LMFT, Director</b>		
ADDRESS <b>1380 Howard St., Fifth Floor San Francisco, CA 94103</b>		
<b>STATE OF CALIFORNIA</b>		
AGENCY NAME <b>Department of Health Care Services</b>		<input checked="" type="checkbox"/> Exempt per: W&I Code §14703
BY (Authorized Signature) 	DATE SIGNED (Do not type)	
PRINTED NAME AND TITLE OF PERSON SIGNING		
ADDRESS <b>1501 Capitol Avenue, Suite 71.2048, MS 1400, P.O. Box 997413, Sacramento, CA 95899-7413</b>		

**Exhibit A  
SCOPE OF WORK**

**1. Service Overview**

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 Francisco 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:

<p><b>Department of Health Care Services</b> Erika Cristo Telephone: (916) 552-9055 Fax: (916) 440-7620 Email: <a href="mailto:Erika.Cristo@dhcs.ca.gov">Erika.Cristo@dhcs.ca.gov</a></p>	<p><b>San Francisco</b> Kavoos Ghane Bassiri , LMFT, Director Telephone: (415) 255-3440 Fax: (415) 255-3567 Email: <a href="mailto:Kavoos.Ghanebassiri@sfdph.org">Kavoos.Ghanebassiri@sfdph.org</a></p>
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B. Direct all inquiries to:

<p><b>Department of Health Care Services</b>  Mental Health Services Division/Program Policy Unit Attention: Dee Taylor 1500 Capitol Avenue, MS 2702 P.O. Box Number 997413 Sacramento, CA, 95899-7413 Telephone: (916) 552-9536 Fax: (916) 440-7620 Email: <a href="mailto:Dee.Taylor@dhcs.ca.gov">Dee.Taylor@dhcs.ca.gov</a></p>	<p><b>San Francisco Community Behavioral Health Services</b>  Attention: Kavoos Ghane Bassiri, LMFT, Director 1380 Howard Street, Fifth Floor, San Francisco, CA, 94103  Telephone: (415) 255-3440 Fax: (415) 255-3567 Email: <a href="mailto:Kavoos.Ghanebassiri@sfdph.org">Kavoos.Ghanebassiri@sfdph.org</a></p>
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**Exhibit A**  
**SCOPE OF WORK**

- 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 §14726. 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 Francisco Community Behavioral Health Services agrees to operate the Mental Health Plan (MHP) for San Francisco 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. Americans with Disabilities Act**

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 and the Americans with Disabilities 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. 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 14 for a detailed description of the services to be performed.



**Exhibit A – Attachment 1**  
**ORGANIZATION AND ADMINISTRATION**

**1. Implementation Plan**

The Contractor shall comply with the provisions of the Contractor's Implementation Plan as approved by the Department, including the administration of beneficiary problem resolution processes. (Cal. Code Regs., 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 CFR 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, 1128A, 1156, or 1842(j)(2) of the Social Security Act. (42 C.F.R. §§ 438.214(d)(1), 438.610(b); 42 U.S.C. § 1320c-5.)
- 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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ORGANIZATION AND ADMINISTRATION**

- 2) A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230. (42 C.F.R. § 438.610(c)(2).)
  - 3) A person with beneficial ownership of 5 percent or more of the Contractor's equity. (42 C.F.R. § 438.610(c)(3).)
  - 4) An individual convicted of crimes described in section 1128(b)(8)(B) of the Act. (42 C.F.R. § 438.808(b)(2).)
  - 5) A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract. (42 C.F.R. § 438.610(c)(4).)
  - 6) The Contractor shall not employ or contract with, directly or indirectly, such individuals or entities for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services (or the establishment of policies or provision of operational support for such services). (42 C.F.R. § 438.808(b)(3).)
- D. The Contractor shall provide to the Department written disclosure of any prohibited affiliation identified by the Contractor or its subcontractors. (42 C.F.R. §438.608(c)(1).)

**3. Delegation**

Unless specifically prohibited by this contract or by federal or state law, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. 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. § 483.230(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

**Exhibit A – Attachment 1  
ORGANIZATION AND ADMINISTRATION**

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. § 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 activities and obligations, including services provided, and related reporting responsibilities. (42 C.F.R. § 438.230(c)(1)(i).)
  - 2) 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

**Exhibit A – Attachment 1**  
**ORGANIZATION AND ADMINISTRATION**

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 as described in Exhibit E, Section 5, Paragraph C and Section 6, Paragraph C.
- 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. §438.3(h).) 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, then. (42 C.F.R. § 438.230(c)(3)(iv).)
- 11) The Department's inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained 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.

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ORGANIZATION AND ADMINISTRATION**

- 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 Act. (42 C.F.R. § 438.3(f)(2).)
- B. 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).)

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- C. No public officials at any level of local government shall make, participate in making, or attempt to use their official positions to influence a decision made within the scope of this Contract in which they know or have reason to know that they have a financial interest. (Gov. Code §§ 87100, 87103; Cal. Code Regs., tit. 2, § 18704; 42 C.F.R. §§ 438.3(f)(2).)
- 1) If a public official determines not to act on a matter due to a conflict of interest within the scope of this Contract, the Contractor shall notify the Department by oral or written disclosure. (Cal. Code Regs, tit. 2, § 18707; 42 C.F.R. § 438.3(f)(2).)
  - 2) Public officials, as defined in Government Code section 87200, shall follow the applicable requirements for disclosure of a conflict of interest or potential conflict of interest, once it is identified, and recuse themselves from discussing or otherwise acting upon the matter. (Gov. Code § 87105, Cal. Code Regs., tit. 2, § 18707(a); 42 C.F.R. § 438.3(f)(2).)
- D. 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) Contractor shall submit documentation to the Department of employees (current and former State employees) who may present a conflict of interest.

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

**1. Provision of Services**

- A. The Contractor shall provide, or arrange and pay for, the following medically necessary covered Specialty Mental Health Services to beneficiaries, as defined for the purposes of this contract, of San Francisco County:
- 1) Mental health services;
  - 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; and,
  - 15) Targeted Case Management.

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

See Exhibit E, Attachment 2, Service Definitions for detailed descriptions of the SMHS listed above.

- B. Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary.
- C. The Contractor shall ensure that all medically necessary covered Specialty Mental Health Services are sufficient in amount, duration, or 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 except as specifically provided in the medical necessity criteria applicable to the situation as provided in the California Code of Regulations, title 9, sections 1820.205, 1830.205, and 1830.210. (42 C.F.R. § 438.210(a)(2) and (3).)
- D. The Contractor shall make all medically necessary covered Specialty Mental Health Services available in accordance with California Code of Regulations, title 9, sections 1810.345, 1810.350 and 1810.405, and 42 Code of Federal Regulations part 438.210.
- E. 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 medical necessity criteria, 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).)
- F. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with California Code of Regulations., title. 9, section 1830.225 and 42 Code of Federal Regulations part 438.3(l).



**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

- G. In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor shall not exclude a beneficiary solely on the ground that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

**2. Requirements for Day Treatment Intensive and Day Rehabilitation**

- A. The Contractor shall require providers to request payment authorization for day treatment intensive and day rehabilitation services:
- 1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.
  - 2) At least every three months for continuation of day treatment intensive.
  - 3) At least every six months for continuation of day rehabilitation.
  - 4) Contractor shall also require providers to request authorization for mental health services, as defined in California Code of Regulations, title 9, section 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in California Code of Regulations, title 9, sections 1810.216 and 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.
- B. The Contractor shall not delegate the payment authorization function to providers. When the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the payment authorization function does not include staff involved in the provision of day treatment intensive, day rehabilitation services, or mental health services provided concurrent to day treatment intensive or day rehabilitation services.
- C. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of California Code of

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

Regulations, title 9, sections 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352.

- D. The Contractor shall require that providers include, at a minimum, the following day treatment intensive and day rehabilitation service components:
- 1) Community meetings. These meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and beneficiaries. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that beneficiaries or staff wish to discuss to elicit support of the group and conflict resolution. Community meetings shall:
    - a) For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.
    - b) For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; and a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.
  - 2) Therapeutic milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

- 3) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.
- 4) Skill-building groups. In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.
- 5) Adjunctive therapies. These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs identified in the client plan.

E. Day treatment intensive shall additionally include:

- 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

**Exhibit A – Attachment 2**  
**SCOPE OF SERVICES**

processes. Psychotherapy shall be provided by licensed, registered, or waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

- 2) Mental Health Crisis Protocol. The Contractor shall ensure that there is an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.
- 3) Written Weekly Schedule. The Contractor shall ensure that a weekly detailed schedule is available to beneficiaries and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

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

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

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

- 2) The Contractor shall require that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.
  - 3) The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.
- G. If a beneficiary is unavoidably absent and does not attend all of the scheduled hours of the day rehabilitation or day treatment intensive program, the Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day. The Contractor shall require that a separate entry be entered in the beneficiary record documenting the reason for the unavoidable absence and the total time (number of hours and minutes) the beneficiary actually attended the program that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.
- H. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation standards described in Attachment 9 of this exhibit. The documentation shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the beneficiary actually attended the program. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist, or a registered nurse who is

**Exhibit A – Attachment 2**  
**SCOPE OF SERVICES**

either staff to the day treatment intensive program or the person directing the services.

- I. The Contractor shall ensure that day treatment intensive and day rehabilitation have at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult beneficiaries may decline this service component. The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.
- J. Written Program Description. The Contractor shall ensure there is a written program description for day treatment intensive and day rehabilitation. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this section. The Contractor shall review the written program description for compliance with this section with prior to the date the provider begins delivering day treatment intensive or day rehabilitation.
- K. Additional higher or more specific standards. The Contractor shall retain the authority to set additional higher or more specific standards than those set forth in this contract, provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.
- L. Continuous Hours of Operation. The Contractor shall ensure that the provider applies the following when claiming for day treatment intensive and day rehabilitation services:
  - 1) A half day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

**Exhibit A – Attachment 2  
SCOPE OF SERVICES**

- 2) A full-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.
- 3) Although the beneficiary must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.
- 4) The requirement for continuous hours or operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

**3. Therapeutic Behavioral Services**

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

**Exhibit A – Attachment 3  
FINANCIAL REQUIREMENTS**

**1. Provider Compensation**

The Contractor shall ensure that no payment is made to a network provider other than payment the Contractor makes for services covered under this Contract, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 Code of Federal Regulations in chapter IV, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the State Plan. (42 C.F.R. § 438.60.)

**2. Payments for Indian Health Care Providers**

- A. Contractor shall make payment to all Indian Health Care Providers (IHCPs) in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 §§ C.F.R. 447.54 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. 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).)

**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:



**Exhibit A – Attachment 3  
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 unless that date is

**Exhibit A – Attachment 3  
FINANCIAL REQUIREMENTS**

extended by the Department, in accordance with the Welf. & Inst. Code § 14705(c), and/or guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the Contractor's chief financial officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to, the Contractor's chief financial officer, or (3) the Contractor's auditor-controller, or equivalent. The cost report shall include both Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual which can be accessed through the Department's Information Technology Web Services (ITWS) for the applicable year, as well as any instructions that are incorporated by reference thereto; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures developed under the Welf. & Inst. Code § 14171.

- B. In accordance with Welf. & Inst. Code § 5655 , the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department, in accordance with Welf.& Inst. Code § 14712(e), may withhold payments of additional funds until the cost report that is due has been submitted.
- C. Upon receipt of an amended cost report, which includes reconciled units of service, and a certification statement that has been signed by the Contractor's Mental Health Director and one of the following: 1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county's auditor controller, or equivalent, the Department shall preliminarily settle the cost report. After completing its preliminary settlement, the Department shall so notify the Contractor if additional FFP is due to the Contractor. The Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority. If funds are due to the State, the Department shall invoice the Contractor and the Contractor shall return the overpayment to the Department.

**Exhibit A – Attachment 3  
FINANCIAL REQUIREMENTS**

**7. Recovery of Overpayments**

- A. The Contractor, and any subcontractor or any network provider of the Contractor, shall report to the Department within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services. (42 C.F.R. § 438.608(c)(3).)
- B. The Contractor, or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures that include provision for the suspension of payments to a network provider for which the State, or 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. (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 (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 CFR §§ 422.208 and 422.210.
  - 2) The Contractor may operate a Physician Incentive Plan only if no specific payment can be made directly or indirectly under a Physician

**Exhibit A – Attachment 3  
FINANCIAL REQUIREMENTS**

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.(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(f).)
- 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. Beneficiary Liability for Payment**

- A. The Contractor or an affiliate, vendor, contractor, or subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments. (Cal. Code Regs., tit. 9, § 1810.365 (a).)
- B. The Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent; for costs of covered services for which the State does not pay the Contractor; for costs of covered services for which the State or the Contractor does not pay the Contractor's network providers; for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary. 42 C.F.R. § 438.106 and Cal. Code Regs. tit 9, § 1810.365(c).)

**Exhibit A – Attachment 3  
FINANCIAL REQUIREMENTS**

- C. The Contractor shall ensure its subcontractors and providers do not bill beneficiaries, for covered services, any amount greater than would be owed if the Contractor provided the services directly (42 C.F.R. § 483.106(c).).

**10. Cost Sharing**

- A. The Contractor shall ensure that any cost sharing imposed on beneficiaries is in accordance with 42 Code of Federal Regulations part 447.50 through 447.82. (42 C.F.R. § 438.108.)
- B. The Contractor shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral. (42 C.F.R. § 447.56(a)(1)(x).)

**11. ICD- 10**

- A. The Contractor shall use the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as the clinical tool to make diagnostic determinations.
- B. Once a DSM-5 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).
- C. 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) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient Medi-Cal specialty mental health services listed in Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 17-004E.
- D. The lists of covered ICD-10 diagnosis codes in MHSUDS Information Notice 17-004E are subject to change and the Department may update them during the term of this contract. Changes to the lists of covered ICD-10 covered diagnoses do not require an amendment to this contract and the Department may implement these changes via Mental Health and Substance Use Disorder Services Information Notices.

**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).)

**Exhibit A – Attachment 4  
MANAGEMENT INFORMATION SYSTEMS**

- C. 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. Medi-Cal Eligibility Data System (MEDS) and MEDS Monthly Extract File (MMEF)**

The Contractor shall enter into a Medi-Cal Privacy and Security Agreement (PSA) with the Department prior to obtaining access to MEDS and the MEDS monthly extract file (MMEF). The Contractor agrees to comply with the provisions as specified in the PSA. The County Mental Health Director or his or her authorized designee shall certify annually that Contractor is in compliance with the PSA agreement. Failure to comply with the terms of the agreement will result in the termination of access to MEDS and MMEF. (42 U.S.C. § 1396a(a)(7); 42 CFR § 431.300(a); 42 C.F.R. § 431.306(b); Welf. & Inst. Code § 14100.2(a).)



**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 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. 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 fair hearings at least annually; and
  - 3) Evaluating requests to change persons providing services at least annually.
  - 4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.
- 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. Contractor's QAPI Program shall include Performance Improvement Projects as specified in paragraph 5.

**2. Quality Improvement (QI) Work Plan**

1. 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, fair hearings, expedited fair hearings, provider appeals, and clinical

**Exhibit A – Attachment 5  
QUALITY IMPROVEMENT SYSTEM**

records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416(a);

- 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

**Exhibit A – Attachment 5  
QUALITY IMPROVEMENT SYSTEM**

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.

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

**Exhibit A – Attachment 5  
QUALITY IMPROVEMENT SYSTEM**

- 7) Incorporating successful interventions into the Contractor's operations as appropriate; and
- 8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

**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).)

**Exhibit A – Attachment 5  
QUALITY IMPROVEMENT SYSTEM**

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

**6. Practice Guidelines**

- 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 contracting health care professionals; and
  - 4) They are reviewed and updated periodically as appropriate. (42 C.F.R. § 438.236(b).)
- C. 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. 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 California Code of Regulations, title 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 medical necessity and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration or scope to reasonably achieve the purpose for which the services are furnished. (42 C.F.R. § 438.210(a)(4)(i), (ii)(A).)

**2. Service Authorization**

- A. Contractor shall implement mechanisms to assure authorization decision standards are met. The Contractor shall:
  - 1) Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. (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

**Exhibit A – Attachment 6  
UTILIZATION MANAGEMENT PROGRAM**

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 I.
- B. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:
- 1) The beneficiary, or the provider, requests extension; or
  - 2) The Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the beneficiary's interest. (42 C.F.R. § 438.210(d)(1))
- 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) 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)).

**Exhibit A – Attachment 6  
UTILIZATION MANAGEMENT PROGRAM**

- 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). The Contractor that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing. (Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).
- F. The Contractor may not require prior authorization for an emergency admission to a psychiatric health facility when the beneficiary has an emergency psychiatric condition. (Cal. Code Regs., tit. 9, §§ 1810.216 and 1830.245).
- G. A Contractor shall authorize out of network services when a beneficiary with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospital services or psychiatric health facility services (Cal. Code Regs., tit. 9 §§ 1830.220, 1810.216, 1820.225, and 1830.245).
- H. 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. A, 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 medical necessity criteria for 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 medical necessity criteria for specialty mental health services. (42 C.F.R. § 438.3(d)(3).)
- D. The Contractor shall not discriminate against Medi-Cal eligible individuals in its county who require an assessment or meet medical necessity criteria for specialty mental health services on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability. (42 C.F.R. § 438.3(d)(4).)

**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).)
- 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).)

**Exhibit A – Attachment 7  
ACCESS AND AVAILABILITY OF SERVICES**

**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 California Code of Regulations., title 9, section 1810.365. (42 C.F.R. § 438.206(b)(5).)
- C. Contractor shall comply with the requirements of California. Code of Regulations, title 9, section 1830.220 regarding providing beneficiaries access to out-of-network providers when a provider is available in Contractor's network.

**4. Procedures for Serving Child Beneficiaries Placed Out-of-County**

- A. In accordance with Cal. Code Regs., tit. 9, § 1830.220, the Contractor in the child's county of origin shall provide or arrange for medically necessary specialty mental health services for children in a foster care aid code residing outside their counties of origin.
- B. The Contractor shall use the standard forms issued by the Department, or the electronic equivalent of those forms generated from the Contractor's Electronic Health Record System, when a child in a foster care aid code is placed outside of his/her county of origin. The standard forms are:
  - 1) Client Assessment,
  - 2) Client Plan,
  - 3) Service Authorization Request,
  - 4) Client Assessment Update,
  - 5) Progress Notes – Day Treatment Intensive Services,

**Exhibit A – Attachment 7  
ACCESS AND AVAILABILITY OF SERVICES**

- 6) Progress Notes – Day Rehabilitation Services,
  - 7) Organizational Provider Agreement (Standard Contract).
- C. The Contractor may request an exemption from using the standard documents if the Contractor is subject to an externally placed requirement, such as a federal integrity agreement, that prevents the use of the standardized forms. The Contractor shall request this exemption from the Department in writing.
- D. The Contractor shall ensure that the MHP in the child’s adoptive parents’ county of residence provides medically necessary specialty mental health services to a child in an Adoption Assistance Program (AAP) aid code residing outside his or her county of origin in the same way as the MHP would provide services to an in-county child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS).
- E. The MHP in the child’s legal guardians’ county of residence shall provide medically necessary specialty mental health services to a child in a Kin-GAP aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility in MEDS.
- F. The Contractor shall comply with timelines specified in Cal. Code Regs., tit. 9, § 1830.220(b)(4)(A)(1-3), when processing or submitting authorization requests for children in a foster care, AAP, or Kinship Guardian Assistance Payment (Kin-GAP) aid code living outside his or her county of origin.
- G. The Contractor shall submit changes to its procedures for serving beneficiaries placed outside their counties of origin pursuant to Welf. & Inst. Code § 14716 when those changes affect 25 percent or more of the Contractor’s beneficiaries placed out of county. The Contractor’s submission shall also include significant changes in the description of the Contractor’s procedures for providing out-of-plan services in accordance with Cal. Code Regs., tit. 9, § 1830.220, when a beneficiary requires services or is placed in a county not covered by the Contractor’s normal procedures.

**Exhibit A – Attachment 7  
ACCESS AND AVAILABILITY OF SERVICES**

**5. 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 his or her 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 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

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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 developed by the Department. (42 C.F.R. § 438.68(a), (b)(1)(iii), (3), 438.206(a).)
- 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.

**4. Timely Access**

- A. Timely Access. In accordance with 42 C.F.R. § 438.206(c)(1), the Contractor shall comply with the requirements set forth in Cal. Code Cal. Code Regs., tit. 9, §1810.405, including the following:
  - 1) Meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services.
  - 2) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor, or another Mental Health Plan.
  - 3) Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
  - 4) Establish mechanisms to ensure that network providers comply with the timely access requirements;
  - 5) Monitor network providers regularly to determine compliance with timely access requirements;

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- 6) Take corrective action if there is a failure to comply with timely access requirements.
- 7) The timeliness standards specified in California Code of Regulations section 1810.405 and Welf. Inst. Code § 14717.1 apply to out-of-plan services, as well as in-plan services.

**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 the network adequacy standards developed by the Department as required by departmental guidance and regulation. (42 C.F.R. § 438.207(a).)
- B. The Contractor shall submit documentation to the Department, in a format specified 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).)
- C. The Contractor shall submit the documentation as specified 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) At any time there has been a significant change, as defined by the Department, in Contractor's operations that would affect the adequacy and capacity of services, including the following:
    - a) A decrease of 25 percent or more in services or providers available to beneficiaries;

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- b) Changes in benefits;
  - c) Changes in geographic service area;
  - d) Composition of or payments to Contractor's provider network; or
  - e) Enrollment of a new population in Contractor's county. (42 C.F.R. § 438.207(c).)
- D. The Contractor shall include details regarding the change and Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

**6. Choice of Provider**

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. 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).)



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- E. The Contractor may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. (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;
  - 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, 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. Contractor shall only use licensed, registered, or waived 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).)

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**8. Provider Certification**

- A. The Contractor shall comply with California Code of Regulations, title 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.
- 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 California Code of Regulations, title 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 California Code of Regulations, title 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

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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.
  - 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,

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as described in California Code of Regulations, title 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 of service, as defined California Code of Regulations, title 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.

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- 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 6 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 6 of this exhibit.
- J. On-site review is not required for hospital outpatient departments which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.
- K. On-site review is not required for primary care and psychological clinics, as defined in Health and Safety Code section 1204.1 and licensed under the Health and Safety Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license.
- L. When on-site review of an organizational provider is required, the Contractor or the Department, as applicable, shall conduct an on-site review at least once every three years. Additional certification reviews of organizational providers may be conducted by the Contractor or Department, as applicable, at its discretion, if:
  - 1) The provider makes major staffing changes.
  - 2) The provider makes organizational and/or corporate structure changes (example: conversion to non-profit status).
  - 3) The provider adds day treatment or medication support services when medications are administered or dispensed from the provider site.
  - 4) There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

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- 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.

**9. Provider Beneficiary Communications**

- A. The Contractor shall not prohibit nor otherwise restrict, a licensed, waived, or registered professional, as defined in California Code of Regulations, title 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

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- 4) The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (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 fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 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 fair hearing after the Contractor has made a determination on an beneficiary's appeal, which is adverse to the beneficiary.
  - 5) The beneficiary's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or state fair 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 fair hearing is pending if the final decision is adverse to the beneficiary.

**Exhibit A – Attachment 9  
DOCUMENTATION REQUIREMENTS**

**1. Documentation Standards**

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

**A. Assessment**

- 1) The Contractor shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed. For children or certain other beneficiaries unable to provide a history, this information may be obtained from the parents/care-givers, etc.
  - a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
  - b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
  - c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;



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DOCUMENTATION REQUIREMENTS**

- d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
- g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
- i) A mental status examination;
- j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,
- k) Additional clarifying formulation information, as needed.

**Exhibit A – Attachment 9  
DOCUMENTATION REQUIREMENTS**

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

**B. Client Plans**

- 1) The Contractor shall ensure that Client Plans:
- a) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
  - b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;
  - c) Have a proposed frequency and duration of intervention(s);
  - d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b)); have interventions that are consistent with the client plan goal;
  - e) Be consistent with the qualifying diagnoses;
  - f) Be signed (or electronic equivalent) by:
    - i. The person providing the service(s), or,
    - ii. A person representing a team or program providing services, or
    - iii. A person representing the Contractor providing services; or
    - iv. By one of the following as a co-signer, if the client plan is used to establish that services are provided under the

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DOCUMENTATION REQUIREMENTS**

direction of an approved category of staff, and if the signing staff is not of the approved category:

- a) A physician,
  - b) A licensed/waivered psychologist,
  - c) A licensed/registered/waivered social worker,
  - d) A licensed/registered/waivered marriage and family therapist, or
  - e) A registered nurse, including but not limited to nurse practitioners, and clinical nurse specialists.
- g) Include documentation of the beneficiary's participation in and agreement with the client plan, as described in Cal. Code Regs., tit. 9, § 1810.440(c)(2)(A)(B).
- i. Examples of acceptable documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary signature on the plan, or a description of the beneficiary's participation and agreement in the client record;
  - ii. The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:
    - a) The beneficiary is expected to be in long term treatment as determined by the MHP and,
    - b) The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service;

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DOCUMENTATION REQUIREMENTS**

- iii. When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.
- 2) There shall be documentation in the client plan that a copy of the client plan was offered to the beneficiary.
- 3) The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition.

C. Progress Notes

- 1) The Contractor shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:
  - a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
  - b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
  - c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;
  - d) The date the services were provided;
  - e) Documentation of referrals to community resources and other agencies, when appropriate;
  - f) Documentation of follow-up care, or as appropriate, a discharge summary; and

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- g) The amount of time taken to provide services; and
  - h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.
- 2) Timeliness/Frequency of Progress Notes. Progress notes shall be documented at the frequency by type of service indicated below:
- a) Every Service Contact:
    - i. Mental Health Services;
    - ii. Medication Support Services;
    - iii. Crisis Intervention;
    - iv. Targeted Case Management;
  - b) Daily:
    - i. Crisis Residential;
    - ii. Crisis Stabilization (1x/23hr);
    - iii. Day Treatment Intensive; and
  - c) Weekly:
    - i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
    - ii. Day Rehabilitation;
    - iii. Adult Residential.

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DOCUMENTATION REQUIREMENTS**

D. Other

- 1) All entries to the beneficiary record shall be legible.
- 2) All entries in the beneficiary record shall include:
  - a) The date of service;
  - b) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.
  - c) The date the documentation was entered in the beneficiary record.
- 3) The Contractor shall have a written definition of what constitutes a long term care beneficiary.
- 4) Contractor shall require providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the beneficiary.

**Exhibit A – Attachment 10  
COORDINATION AND CONTINUITY OF CARE**

**A. 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 his or her 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).)

**Exhibit A – Attachment 10  
COORDINATION AND CONTINUITY OF CARE**

- B. 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 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. (Cal. Code Regs., tit. 9, § 1810.370.)
  
- C. The Contractor shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (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. (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. (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. (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. 438.62(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;

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INFORMATION REQUIREMENTS**

- 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 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).)

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- 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, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. (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 are available in alternative formats, including large print, upon request of the potential beneficiary or beneficiary at no cost. Large print means printed in a font size no smaller than 18 point. (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 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 include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (42 C.F.R. § 438.10(d)(2).)
  - 2) The Contractor shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit. (42 C.F.R. § 438.10(d)(3).)

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- 3) The Contractor shall notify beneficiaries that written translation is available in prevalent languages free of cost and shall notify beneficiaries how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Cal. Code Regs., tit. 9, § 1810.410, subd. (e), para. (4).)
  - 4) 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).) Contractor shall also notify beneficiaries how to access these services. (42 C.F.R. § 438.10(d) (5)(ii)-(iii).)
- E. The Contractor shall make oral interpretation and auxiliary aids, such as 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 that the service is available and how to access those services. (42 C.F.R. § 438.10(d)(5)(i), (iii).)

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

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

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- 3) The availability of assistance in the filing process;
  - 4) The right to request a state fair 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 fair 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 fair 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 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.

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- 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 California Code of Regulations, title 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.

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**5. Provider Directory**

- A. The Contractor shall make provider directories available in electronic and paper form, and ensure that the provider directories include:
- 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, and whether the provider has completed cultural competence training. (42 C.F.R. § 438.10(h)(1)(vii).)
  - 4) Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 C.F.R. § 438.10(h)(1)(viii).)
  - 5) A means to identify which providers are accepting new beneficiaries. (42 C.F.R. § 438.10(h)(1)(vi).)
- B. 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. (42 C.F.R. § 438.10(h)(3).)
- C. 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.)



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- 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).)
- 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 Welfare and Institutions Code 5325, California Code of Regulations, title 9, sections 862 through 868, and 42 Code of Federal Regulations section 438.100. The Contractor shall ensure that its subcontractors comply with all applicable patients' rights laws and regulations.
- B. The Contractor shall have written policies regarding the 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 his or her dignity and privacy. (42 C.F.R. § 438.100(b)(2)(ii).)

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- 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 his or her health care, including the right to refuse treatment. (42 C.F.R. § 438.100(b)(2)(iv).)
- 5) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. (42 C.F.R. § 438.100(b)(2)(v).)
- 6) Request and receive a copy of his or her 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 his or her 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 fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of adverse benefit determination. For the purposes of this Section, a Contractor provider site means

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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 fair 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 fair 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).)

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- 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 fair 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

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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 his or her 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

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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 his or her 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

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name of the covered person whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6).)

- 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. 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



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14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. (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. Contractor's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees 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.)

- C. 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 he or she could not be contacted. (Cal. Code Regs., tit. 9, § 1850.206(c).)
- D. 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. 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

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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 determines that there is a need for additional information and that the delay is in the beneficiary's interest. (42 CFR 438.408(c)(1); 42 CFR 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. Contractor's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees with the Contractor's decision. 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 his or her 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

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- 6) Provide the beneficiary and his or her 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, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal. (42 CFR 438.406(b)(6).)
- B. The Contractor shall notify the beneficiary, and/or his or her representative, of the resolution of the appeal in writing in a format and language that, at a minimum, meets applicable notification standards. (42 CFR 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 fair hearing and the procedure for requesting a fair hearing, if the beneficiary has not already requested a fair 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 fair hearing is pending and how to request the continuation of benefits; (42 C.F.R. § 438.408(e)(2)(ii).)

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- c) Inform the beneficiary that he or she 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).)

**5. 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:
  - 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 CFR 438.406(b)(4); 42 CFR 438.408(b)-(c).)
  - 5) Resolve an expedited appeal and notify the affected parties in writing, as expeditiously as the beneficiary's health condition

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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 determines 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 his or her 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 his or her 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 he or she disagrees with the

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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.)

**6. Contractor obligations related to State Fair Hearing**

State “Fair Hearing” means the State hearing provided to beneficiaries pursuant to sections 50951 and 50953 of Title 22 of the California Code of Regulations section and section 1810.216.6 of Title 9 of the California Code of Regulations 1810.216.6.:

- A. If a beneficiary requests a State Fair Hearing, the Department shall grant the request. (42 C.F.R. § 431.220(a)(5).) The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or Notice of 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 Fair 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 fair hearing. (42 CFR 438.408(f)(1)(i); 42 CFR 438.402(c)(1)(i)(A).)
  - 3) The provider may request a State Fair 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).)

**7. Expedited Fair Hearing**

“Expedited Fair Hearing” means a fair hearing, used when the Contractor determines, or the beneficiary or the beneficiary’s provider certifies that following the 90 day timeframe for a fair hearing as established in 42 C.F.R. §

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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.)

**8. 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 fair 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).)
  - 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 fair hearing is pending, the benefits must



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be continued until the beneficiary withdraws the appeal or request for state fair hearing, the beneficiary does not request a state fair 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 fair 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 fair hearing was pending if the final resolution of the appeal or state fair 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 fair 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.)

**9. 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).)



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- 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).)
- 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 NOA shall contain the items specified in 42 Code of Federal Regulations part 438.404 (b) and California Code of Regulations, title 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 California Code of Regulations, title 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

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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).)
- 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 medical necessity criteria in sections 1830.205(b)(1),(b)(2),(b)(3)(C), or 1830.210(a) of Title 9 of the California Code of Regulations 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).)

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- 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.

**10. 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 medical necessity criteria, 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).)

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- 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 fair 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 fair hearing or an expedited fair hearing, including:
    - a) The method by which a hearing may be obtained; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(A).)
    - b) A statement that the 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 fair hearing is requested; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(C).) and
    - d) The time limits for requesting a fair hearing or an expedited fair 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

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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).)
- 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,

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- 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 his or her 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 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

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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 he or she is ineligible for further services; (42 C.F.R. § 431.213(c).)
- 4) The beneficiary's whereabouts are unknown and mail directed to him or her 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).)
- 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 NF transfers).

**11. 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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**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



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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).)

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**4. Fraud Reporting Requirements**

- A. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to the Department about the following:
- 1) Any potential fraud, waste, or abuse. (42 C.F.R. §438.608(a), (a)(7).)
  - 2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. §438.608(a), (a)(2).)
  - 3) Information about changes in a 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).)

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- 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).)

**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. §

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PROGRAM INTEGRITY**

455.101. For purposes of this disclosure, Contractor may use the business address for any member of its Board of Supervisors.

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

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PROGRAM INTEGRITY**

- 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, 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 – 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.

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PROGRAM INTEGRITY**

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

**C. Disclosures Related to Persons Convicted of Crimes**

- 1) 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

**Exhibit A – Attachment 14  
REPORTING REQUIREMENTS**

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.)

- 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



**Exhibit A – Attachment 14  
REPORTING REQUIREMENTS**

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

- 1) Enrollment and disenrollment data;
- 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.

**Exhibit B**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

**1. Payment Provisions**

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

**2. Budget Contingency Clause**

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

**A. Federal Budget**

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

**B. Delayed Federal Funding**

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

**3. Federal Financial Participation**

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

**Exhibit B**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

Welf. & Inst. Code § 14705(d), the Contractor shall certify to the state that it has incurred public expenditures prior to requesting the reimbursement of federal funds.

**4. Audits and Recovery of Overpayments**

- A. Pursuant to Welf. & Inst. Code § 14707, in the case of federal audit exceptions, the Department will follow federal audit appeal processes unless the Department, in consultation with the California Mental Health Director's Association, determines that those appeals are not cost beneficial.
- 1) Whenever there is a final federal audit exception against the State resulting from a claim for federal funds for an expenditure by individual counties that is not federally allowable, the department may offset federal reimbursement and request the Controller's office to offset the distribution of funds to the Contractor from the Mental Health Subaccount, the Mental Health Equity Subaccount and the Vehicle License Collection Account of the Local Revenue Fund; funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011; and any other mental health realignment funds from which the Controller makes distributions to the counties by the amount of the exception. The Department shall provide evidence to the Controller that the county had been notified of the amount of the audit exception no less than 30 days before the offset is to occur.
  - 2) The Department will involve the Contractor in developing responses to any draft federal audit reports that directly impact the county.
- B. Pursuant to Welf. & Inst. Code § 14718(b)(2), the Department may offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the Contractor.
- 1) The Department may offset the amount of any state disallowance, audit exception, or overpayment for fiscal years through and including 2010-11 against subsequent claims from the Contractor.
  - 2) Offsets may be done at any time, after the department has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the mental health plan.

**Exhibit B**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

- 3) The maximum withheld amount shall be 25 percent of each payment as long as the Department is able to comply with the federal requirements for repayment of FFP pursuant 42 United States Code (U.S.C.) §1396b(d)(2)). The Department may increase the maximum amount when necessary for compliance with federal laws and regulations.
- C. Pursuant to the Welf. & Inst. Code § 14170, cost reports submitted to the Department are subject to audit in the manner and form prescribed by the Department. The year-end cost report shall include both Contractor's costs and the costs of its subcontractors, if any. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. In accordance with the Welf. & Inst. Code § 14170, any audit of Contractor's cost report shall occur within three years of the date of receipt by the Department of the final cost report with signed certification by the Contractor's Mental Health Director and one of the following: (1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county auditor controller, or equivalent. Both signatures are required before the cost report shall be considered final. For purposes of this section, the cost report shall be considered audited once the Department has informed the Contractor of its intent to disallow costs on the cost report, or once the Department has informed the Contractor of its intent to close the audit without disallowances.
- D. If the adjustments result in the Department owing FFP to the Contractor, the Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority.

**5. Claims Adjudication Process**

- A. In accordance with the Welf. & Inst. Code §14705(c), claims for federal funds in reimbursement for services shall comply with eligibility and service requirements under applicable federal and state law.
- B. The Contractor shall certify each claim submitted to the Department in accordance with Cal. Code Regs., tit. 9, § 1840.112 and 42 C.F.R. § 433.51, at the time the claims are submitted to the Department. The Contractor's Chief Financial Officer or his or her equivalent, or an individual with authority delegated by the county auditor-controller, shall sign the certification, declaring, under penalty of perjury, that the Contractor has incurred an expenditure to cover the services included in the claims to satisfy the requirements for FFP. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director

**Exhibit B**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

shall sign the certification, declaring, under penalty of perjury that, to the best of his or her knowledge and belief, the claim is in all respects true, correct, and in accordance with the law and meets the requirements of Cal. Code Regs., tit. 9, § 1840.112(b). The Contractor shall have mechanisms that support the Mental Health Director's certification, including the certification that the services for which claims were submitted were actually provided to the beneficiary. If the Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 C.F.R. § 438.604.

- C. Claims not meeting federal and/or state requirements shall be returned to Contractor as not approved for payment, along with a reason for denial. Claims meeting all Health Insurance Portability and Accountability Act (HIPAA) transaction requirements and any other applicable federal or state privacy laws or regulations and certified by the Contractor in accordance with Cal. Code Regs., tit. 9, §1840.112, shall be processed for adjudication.
- D. Good cause justification for late claim submission is governed by applicable federal and state laws and regulations and is subject to approval by the Department.
- E. In the event that the Department or the Contractor determines that changes requiring a change in the Contractor's or Department's obligation must be made relating to either the Department's or the Contractor's claims submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated requirements and impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.
- F. The Contractor shall comply with Cal. Code Regs., tit. 9, § 1840.304, when submitting claims for FFP for services billed by individual or group providers. The Contractor shall submit service codes from the Health Care Procedure Coding System (HCPCS) published in the most current Mental Health Medi-Cal billing manual.

**6. Payment Data Certification**

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

**Exhibit B**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

**7. System Changes**

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

**8. Administrative Reimbursement**

- A. The Contractor may submit claims for reimbursement of Medical Administrative Activities (MAA) pursuant to Welf. & Inst. Code § 14132.47. The Contractor shall not submit claims for MAA unless it has submitted a claiming plan to the Department which was approved by the Department and is effective during the quarter in which the costs being claimed were incurred. In addition, the Contractor shall not submit claims for reimbursements of MAA that are not consistent with the Contractor's approved MAA claiming plan. The Contractor shall not use the relative value methodology to report its MAA costs on the year-end cost report. Rather, the Contractor shall calculate and report MAA units on the cost report by multiplying the amount of time (minutes, hours, etc.) spent on MAA activities by the salary plus benefits of the staff performing the activity and then allocating indirect administrative and other appropriately allocated costs.
- B. Pursuant to the Welf. & Inst. Code § 14711(c), administrative costs shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medicaid state plans and waivers and shall be limited to 15 percent of the total actual cost of direct client services. The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative costs.

**9. Notification of Request for Contract Amendment**

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

**Exhibit E**  
**ADDITIONAL PROVISIONS**

**1. Additional Incorporated Exhibits**

A. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit A, Attachment 9	Documentation Requirements	7 page(s)
2) Exhibit A, Attachment 10	Coordination And Continuity Of Care	2 page(s)
3) Exhibit A, Attachment 11	Information Requirements	10 pages
4) Exhibit A, Attachment 12	Beneficiary Problem Resolution	21 page
5) Exhibit A, Attachment 13	Program Integrity	7 pages
6) Exhibit A, Attachment 14	Reporting Requirements	3 pages
7) Exhibit B	Budget Detail And Payment Provisions	5 pages
8) Exhibit C *	General Terms And Conditions	<a href="#">GTC 04/2017</a>
9) Exhibit D (F)	Special Terms And Conditions (Attached hereto as part of this agreement) (Notwithstanding Provisions 2, 3, 4, 6 ,8, 12, 14, 22, 25, 29, and 30 which do not apply to this agreement.)	26 pages
10) Exhibit E	Additional Provisions (Program Terms And Conditions)	16 pages
11) Exhibit E, Attachment 1	Definitions	4 pages
12) Exhibit E, Attachment 2	Service Definitions	6 pages
13) Exhibit F	HIPAA Business Associate Addendum	27 pages
14) Exhibit F, Attachment B	Information Security Exchange Agreement between the Social Security Administration (SSA) and the California Department of Health Care Services (DHCS)	101 pages

**2. Amendment Process**

Should either party, during the term of this Contract, desire a change or amendment to the terms of this Contract, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether

**Exhibit E**  
**ADDITIONAL PROVISIONS**

the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

**3. Cancellation/Termination**

A. General Provisions

- 1) As required by, if the Contractor decides not to contract with the Department, does not renew its contract, or is unable to meet the standards set by the Department, the Contractor agrees to inform the Department of this decision in writing. (Welf. & Inst. Code § 14712(c)(1).)
- 2) If the Contractor is unwilling to contract for the delivery of specialty mental health services or if the Department or Contractor determines that the Contractor is unable to adequately provide specialty mental health services or that the Contractor does not meet the standards the Department deems necessary for a mental health plan, the Department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries. (Welf. & Inst. Code § 147122(c)(2), (3).)
- 3) The Department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the Department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the Department. The Contractor may not subsequently contract to provide specialty mental health services unless the Department elects to contract with the Contractor. (Welf. & Inst. Code § 147122(c)(4).)
- 4) If the Contractor does not contract with the Department to provide specialty mental health services, the Department will work with the Department of Finance and the Controller to obtain funds from the Contractor in accordance with Government (Govt.) Code 30027.10. (Welf. & Inst. Code § 147122(d).)

A. Contract Renewal



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**ADDITIONAL PROVISIONS**

- 1) This contract may be renewed if the Contractor continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. (42 C.F.R. § 438.708; Welf. & Inst. Code § 14714(b)(1).) The Department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract. (Welf. & Inst. Code § 14714(b)(1).)
- 2) In the event the contract is not renewed based on the reasons specified in (1), the Department will notify the Department of Finance, the fiscal and policy committees of the Legislature, and the Controller of the amounts to be sequestered from the Mental Health Subaccount, the Mental Health Equity Account, and the Vehicle License Fee Collection Account of the Local Revenue Fund and the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and the Controller will sequester those funds in the Behavioral Health Subaccount pursuant to Govt. Code § 30027.10. Upon this sequestration, the Department will use the funds in accordance with Govt. Code § 30027.10. (Welf. & Inst. Code § 14714(b)(3).)

**B. Contract Amendment Negotiations**

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

**Exhibit E**  
**ADDITIONAL PROVISIONS**

amendment is approved by the Department of General Services, if necessary.

**D. Contract Termination**

The Department or the Contractor may terminate this contract in accordance with, and within the given timeframes provided in California Code of Regulations, title 9, section 1810.323.

- 1) DHCS reserves the right to cancel or terminate this Contract immediately for cause.
- 2) The term “for cause” shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Contract.
- 3) Contract termination or cancellation shall be effective as of the date indicated in DHCS’ notification to the Contractor. The notice shall identify any final performance, invoicing or payment requirements.
- 4) Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel, or if cancellation is not possible reduce, subsequent contract costs.
- 5) In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Contract and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.
- 6) The Department will immediately terminate this Contract if the Department finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons will be subject to reasonable notice to the Contractor of the Department's intent to terminate, as well as notification to affected beneficiaries. (Welf. & Inst. Code § 14714(d).)

**E. Termination of Obligations**

**Exhibit E**  
**ADDITIONAL PROVISIONS**

- 1) All obligations to provide covered services under this contract shall automatically terminate on the effective date of any termination of this contract. The Contractor shall be responsible for providing covered services to beneficiaries until the termination or expiration of the contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to beneficiaries prior to such expiration or termination.
- 2) When Contractor terminates a subcontract with a provider, Contractor shall make a good faith effort to provide notice of this termination, within 15 days, to the persons that Contractor, based on available information, determines have recently been receiving services from that provider.

**F. Contract Disputes**

Should a dispute arise between the Contractor and the Department relating to performance under this contract, other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, California Code of Regulations, title 9, or the processes governing the audit appeals process in Chapter 9 of Division 1, California Code of Regulations, title 9 the Contractor shall follow the Dispute Resolution Process outlined in provision number 15 of Exhibit D(F) which is attached hereto as part of this contract.

**4. Fulfillment of Obligation**

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

**5. Additional Provisions**

**A. Inspection Rights/Record Keeping Requirements**

**Exhibit E**  
**ADDITIONAL PROVISIONS**

- 1) Provision number seven (Audit and Record Retention) of Exhibit D(F), which is attached hereto as part of this Contract, supplements the following requirements.
- 2) The Contractor, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. Contractor shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.
- 3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract, including beneficiary grievance and appeal records identified in Attachment 12, Section 2 and the data, information and documentation specified in 42 Code of Federal Regulations parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion

**Exhibit E**  
**ADDITIONAL PROVISIONS**

of all legal remedies, whichever is later. (42 C.F.R. § 438.3(u); See also § 438.3(h).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

**B. Notices**

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

Department of Health Care Services  
Mental Health Services Division  
1500 Capitol Avenue, MS 2702  
P.O. Box 997413  
Sacramento, CA 95899-7413

San Francisco Community Behavioral  
Health Services  
1380 Howard Street, Fifth Floor  
San Francisco, CA 94103

**C. Nondiscrimination**

- 1) Consistent with the requirements of applicable federal law, such as 42 Code of Federal Regulations, part 438.3(d)(3) and (4), and state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability.
- 2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human Services,

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effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977.

- 3) The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.
- 4) Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to California Code of Regulations, title 9, sections 1820.205, 1830.205 and/or 1830.210, prior to providing covered services to a beneficiary.

**D. Relationship of the Parties**

The Department and the Contractor are, and shall at all times be deemed to be, independent agencies. Each party to this contract shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this contract. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department and its agents and employees shall not be entitled to any rights or privileges of the Contractor's employees and shall not be considered in any manner to be Contractor employees. The Contractor and its agents and employees, shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

**E. Waiver of Default**

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

**6. Duties of the State**

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**ADDITIONAL PROVISIONS**

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

A. Payment for Services

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

B. Reviews

The Department shall conduct reviews of access to and quality of care in Contractor's county at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, pursuant to California Code of Regulations, title 9, sections 1810.380 and 1810.385. The Department shall also arrange for an annual external quality review of the Contractor as required by 42 Code of Federal Regulations, part 438.350 and California Code of Regulations, title 9, section 1810.380(a)(7).

C. Monitoring for Compliance

When monitoring activities identify areas of non-compliance, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action. Cal. Code Reg., tit. 9, § 1810.380. Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to Cal. Code Reg., tit. 9, § 1810.385.

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

E. If the Contractor has not previously implemented a Mental Health Plan or Contractor will provide or arrange for the provision of covered benefits to new eligibility groups, then the Contractor shall develop an Implementation



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**ADDITIONAL PROVISIONS**

Plan (as defined in Cal. Code Regs., tit. 9, § 1810.221) that is consistent with the readiness review requirements set forth in 42 Code of Federal Regulations, part 438.66(d)(4), and the requirements of Cal. Code Regs., tit. 9, § 1810.310 (a). (See 42 C.F.R. § 438.66(d)(1), (4).) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to the Contractor within 60 days of the receipt of the Implementation Plan. (Cal. Code Regs., tit. 9, § 1810.310(b).) A Contractor shall submit proposed changes to its approved Implementation Plan in writing to the Department for review. A Contractor shall submit proposed changes in the policies, processes or procedures that would modify the Contractor's current Implementation Plan prior to implementing the proposed changes.(See Cal. Code Regs., tit. 9, § 1810.310 (b)-(c)).

- F. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Cal. Code Regs., tit. 9, § 1810.410. The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for the disapproval, to the Contractor within 60 calendar days after receipt of the plan from the Contractor. If the Department fails to provide a Notice of Approval or Disapproval, the Contractor may implement the plan 60 calendar days from its submission to the Department.
- G. Certification of Organizational Provider Sites Owned or Operated by the Contractor
- 1) The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with California Code of Regulations, title 9, section 1810.435, and the requirements specified in Exhibit A, Attachment 3, Section 6 of this contract. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every three years after that date, unless the Department determines an earlier date is necessary. The on-site review required by Cal. Code Regs., tit. 9, § 1810.435(e), shall be conducted of any site owned, leased, or operated by the Contractor and used for to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.



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- 2) The Department may allow the Contractor to begin delivering covered services to beneficiaries at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained, whichever date is latest.
- 3) The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational and has all required fire clearances.
- 4) Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of FFP by the Contractor and the Department's tracking of that information.

H. Excluded Providers

- 1) If the Department learns that the Contractor has a prohibited affiliation, as described in Attachment 1, Section 2, the Department:
  - a) Must notify the Secretary of the noncompliance.
  - b) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
  - c) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.
  - d) Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under

**Exhibit E**  
**ADDITIONAL PROVISIONS**

sections 1128, 1128A or 1128B of the Act. (42 C.F.R.  
§438.610(d).)

I. Sanctions

The Department shall conduct oversight and impose sanctions on the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations, in accordance with Welf. & Inst. Code § 14712(e) and Cal. Code Regs., tit. 9, §§ 1810.380 and 1810.385.

J. Notification

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

K. Performance Measurement

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

**7. State and Federal Law Governing this Contract**

- A. Contractor agrees to comply with all applicable federal and state law, including the applicable sections of the state plan and waiver, including but not limited to the statutes and regulations incorporated by reference below in Sections C, E, and F, in its provision of services as the Mental Health Plan. Contractor agrees to comply with any changes to these statutes and regulations that may occur during the contract period and any new applicable statutes or regulations. These obligations shall not apply without the need for a Contract amendment(s). To the extent there is a conflict between federal or state law or regulation and a provision in this contract, Contractor shall comply with the federal or state law or regulation and the conflicting Contract provision shall no longer be in effect.
- B. Contractor agrees to comply with all existing policy letters issued by the Department. All policy letters issued by the Department subsequent to the effective date of this Contract shall provide clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to

**Exhibit E**  
**ADDITIONAL PROVISIONS**

State or federal statutes or regulations, or pursuant to judicial interpretation.

C. Federal law:

- 1) Title 42 United States Code, to the extent that these requirements are applicable;
- 2) 42 C.F.R. to the extent that these requirements are applicable;
- 3) 42 C.F.R. Part 438, Medicaid Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHPs), except for the provisions listed in paragraph D and E, below.
- 4) 42 C.F.R. § 455 to the extent that these requirements are applicable;
- 5) Title VI of the Civil Rights Act of 1964
- 6) Title IX of the Education Amendments of 1972
- 7) Age Discrimination Act of 1975
- 8) Rehabilitation Act of 1973
- 9) Americans with Disabilities Act
- 10) Section 1557 of the Patient Protection and Affordable Care Act
- 11) Deficit Reduction Act of 2005;
- 12) Balanced Budget Act of 1997.
- 13) The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act, which requires that all contracts and subcontracts in excess of \$2000 for construction or repair awarded by the Contractor and its subcontractors shall include a provision for compliance with the Copeland Anti-Kickback Act.
- 14) The Contractor shall comply with the provisions of the Davis-Bacon Act, as amended, which provides that, when required by Federal Medicaid program legislation, all construction contracts awarded by

**Exhibit E**  
**ADDITIONAL PROVISIONS**

the Contractor and its subcontractors of more than \$2,000 shall include a provision for compliance with the Davis-Bacon Act as supplemented by Department of Labor regulations.

- 15) The Contractor shall comply with the provisions of the Contract Work Hours and Safety Standards Act, as applicable, which requires that all subcontracts awarded by the Contractor in excess of \$2,000 for construction and in excess of \$2,500 for other subcontracts that involve the employment of mechanics or laborers shall include a provision for compliance with the Contract Work Hours and Safety Standards Act.
- 16) Any applicable federal and state laws that pertain to beneficiary rights.

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

- 1) §438.3(b) Standard Contract Provisions – Entities eligible for comprehensive risk contracts
- 2) §438.3(c) Standard Contract Provisions - Payment
- 3) §438.3(g) Standard Contract Provisions - Provider preventable conditions
- 4) §438.3(o) Standard Contract Provisions - LTSS contract requirements
- 5) §438.3(p) Standard Contract Provisions – Special rules for HIOs
- 6) §438.3(s) Standard Contract Provisions – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs
- 7) §438.4 Actuarial Soundness
- 8) §438.5 Rate Development Standards
- 9) §438.6 Special Contract Provisions Related to Payment
- 10) §438.7 Rate Certification Submission

**Exhibit E**  
**ADDITIONAL PROVISIONS**

- 11) §438.8 Medical Loss Ratio Standards
  - 12) §438.9 Provisions that Apply to Non-emergency Medical Transportation
  - 13) §438.50 State Plan Requirements
  - 14) §438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities
  - 15) §438.56 Disenrollment: requirements and limitations
  - 16) §438.70 Stakeholder engagement when LTSS is delivered through a managed care program
  - 17) 438.74 State Oversight of the Minimum MLR Requirements
  - 18) §438.104 Marketing
  - 19) §438.110 Member advisory committee
  - 20) §438.114 Emergency and Post-Stabilization
  - 21) §438.362 Exemption from External Quality Review
  - 22) §438.700-730 Basis for Imposition of Sanctions
  - 23) §438.802 Basic Requirements
  - 24) §438.810 Expenditures for Enrollment Broker Services
  - 25) §438.816 Expenditures for the beneficiary support system for enrollees using LTSS
- E. Specific provisions of 42 Code of Federal Regulations, part 438 relating to the following subjects are inapplicable to this Contract:
- 1) Long Terms Services and Supports
  - 2) Managed Long Terms Services and Supports
  - 3) Actuarially Sound Capitation Rates

**Exhibit E**  
**ADDITIONAL PROVISIONS**

- 4) Medical Loss Ratio
  - 5) Religious or Moral Objections to Delivering Services
  - 6) Family Planning Services
  - 7) Drug Formularies and Covered Outpatient Drugs
- F. Pursuant to Welfare & Institutions Code section 14704, a regulation or order concerning Medi-Cal specialty mental health services adopted by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000), as in effect preceding the effective date of this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by DHCS, or until it expires by its own terms.
- G. State Law:
- 1) Division 5, Welfare & Institutions Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 2) Welf. & Inst. Code §§ 14680-14685.1
  - 3) Welf. & Inst. Code §§ 14700-14726
  - 4) Chapter 7, Part 3, Division 9, Welf. & Inst. Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 5) Cal. Code Regs., tit. 9, § 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services
  - 6) Cal. Code Regs., tit. 22, §§ 50951 and 50953
  - 7) Cal. Code Regs., tit. 22, §§ 51014.1 and 51014.2

**Exhibit E – Attachment 1  
DEFINITIONS**

1. The following definitions and the definitions contained in California Code of Regulations, title 9, sections 1810.100-1850.535 shall apply in this contract. If there is a conflict between the following definitions and the definitions in California Code of Regulations, title 9, sections 1810.100-1850.535, the definitions below will apply.
  - A. “Advance Directives” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the healthcare when the individual is incapacitated.
  - B. “Abuse” means, as the term described in, provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)
  - C. “Appeal” means a review by the Contractor of an adverse benefit determination.
  - D. “Beneficiary” means a Medi-Cal recipient who is currently receiving services from the Contractor.
  - E. "Contractor" means San Francisco Community Behavioral Health Services.
  - F. "Covered Specialty Mental Health Services" are defined in Exhibit E, Attachment 2.
  - G. "Department" means the California Department of Health Care Services (DHCS).
  - H. “Director” means the Director of DHCS.
  - I. “Emergency” means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (Health & Safety Code § 1797.07).
  - J. “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some

**Exhibit E – Attachment 1**  
**DEFINITIONS**

unauthorized benefit to self or some other person. It includes an act that constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)

- K. “Grievance” means an expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights regardless of whether remedial action is requested. Grievance includes a beneficiary’s right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400)
- L. “Habilitative services and devices” help a person keep, learn, or improve skills and functioning for daily living. (45 C.F.R. § 156.115(a)(5)(i))
- M. “HHS” means the United States Department of Health and Human Service
- N. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association, or the American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)
- O. A “Network Provider” means any provider, group of providers, or entity that has a network provider agreement with a Mental Health Plan, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department’s contract with a Mental Health Plan. A network provider is not a subcontractor by virtue of the network provider agreement. (42 C.F.R. § 438.2)
- P. “Out-of-network provider” means a provider or group of providers that does not have a network provider agreement with a Mental Health Plan, or with a subcontractor. (A provider may be “out of network” for one Mental Health Plan, but in the network of another Mental Health Plan.)
- Q. “Out-of-plan provider” has the same meaning as out-of-network provider.
- R. “Provider” means a person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to



**Exhibit E – Attachment 1**  
**DEFINITIONS**

provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

- S. “Overpayment” means any payment made to a network provider by a Mental Health Plan to which the provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)
- T. “Physician Incentive Plans” mean any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.
- U. “PIHP” means Prepaid Inpatient Health Plan. . A Prepaid Inpatient Health Plan is an entity that:
- 1) Provides medical services to beneficiaries under contract with the Department of Health Care Services, and on the basis of prepaid capitation payments, or other payment arrangement that does not use state plan rates;
  - 2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and
  - 3) Does not have a comprehensive risk contract. (42 C.F.R. § 438.2)
- V. "Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries. (California's

**Exhibit E – Attachment 1  
DEFINITIONS**

Medicaid State Plan, State Plan Amendment 10-016, Attachment 3.1-A, Supplement 3, p. 2a.)

- W. “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.
- X. "Subcontract" means an agreement entered into by the Contractor with any of the following:
- 1) Any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this contract.
  - 2) “Subcontractor” means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. Notwithstanding the foregoing, for purposes of Exhibit D(F) the term “subcontractor” shall include network providers.

**Exhibit E – Attachment 2  
SERVICE DEFINITIONS**

1. The Contractor shall provide, or arrange and pay for, the following medically necessary covered Specialty Mental Health Services to beneficiaries of San Francisco County. Services shall be provided based on medical necessity criteria, in accordance with an individualized Client Plan, and approved and authorized according to State of California requirements. Services include:
  - A. Mental Health Services Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:
    - 1) Assessment - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.
    - 2) Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.
    - 3) Therapy - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.
    - 4) Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.
    - 5) Collateral - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited

**Exhibit E – Attachment 2**  
**SERVICE DEFINITIONS**

to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

- B. Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.
- C. Day Treatment Intensive are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- D. Day Rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

**Exhibit E – Attachment 2**  
**SERVICE DEFINITIONS**

- E. Crisis Intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.
- F. Crisis Stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- G. Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- H. Crisis Residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.
- I. Psychiatric Health Facility Services—A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. “Psychiatric Health Facility Services” are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated

**Exhibit E – Attachment 2  
SERVICE DEFINITIONS**

general acute care hospital or in outpatient settings. These services are separate from those categorized as “Psychiatric Inpatient Hospital”.

- J. Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:
- 1) Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
  - 2) Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
  - 3) Supports the parent/caregiver in meeting their child/youth’s needs;
  - 4) Helps establish the CFT and provides ongoing support; and
  - 5) Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community
- K. Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth’s functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth’s family’s ability to help the

**Exhibit E – Attachment 2  
SERVICE DEFINITIONS**

child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Core Practice Model (CPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

- L. Therapeutic Behavioral Services (TBS) are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.
- M. Therapeutic Foster Care (TFC) Services model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized SMHS activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma informed interventions that are medically necessary for the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).
- N. Psychiatric Inpatient Hospital Psychiatric Inpatient Hospital Services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute



**Exhibit E – Attachment 2**  
**SERVICE DEFINITIONS**

psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

- O. Targeted Case Management Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.



**Special Terms and Conditions**

*(For federally funded service contracts or agreements and grant agreements)*

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, "agreement", "grant", "grant agreement", "Grantee" and "Subgrantee" respectively.

The terms "California Department of Health Care Services", "California Department of Health Services", "Department of Health Care Services", "Department of Health Services", "CDHCS", "DHCS", "CDHS", and "DHS" shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

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## 1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

- a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
- e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

- g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

## 2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

## 3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

### a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

- (1) **Major equipment/property:** A tangible or intangible item having a base unit cost of **\$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.
  - (2) **Minor equipment/property:** A tangible item having a base unit cost of **less than \$5,000** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.
- b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.
- c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.
- (1) Equipment/property purchases shall not exceed \$50,000 annually.

To secure equipment/property above the annual maximum limit of \$50,000, the Contractor shall

make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

- (2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.
- (3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:
  - (a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
  - (b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.
  - (c) Procurements shall be conducted in a manner that provides for all of the following:
    - [1] Avoid purchasing unnecessary or duplicate items.
    - [2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.
    - [3] Take positive steps to utilize small and veteran owned businesses.
- d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of \$5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.
- e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.
- f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.
- g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.
- h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

#### 4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

- a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

- (1) **Reporting of Equipment/Property Receipt** - DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

- (2) **Annual Equipment/Property Inventory** - If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

- (a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).
- (b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.
- (c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

- b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.
- c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.
- d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.

- (1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.

- e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.



- f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

- (1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.
- (2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.
- (3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.
- (4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

**Automobile Liability Insurance**

- (a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of \$1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.
- (b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.
- (c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.
- (d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.
- (e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

- [1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).
  - [2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.
  - [3] The insurance carrier shall notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to each agreement number for which the insurance was obtained.
- (f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.
- (g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

## 5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

- a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing \$5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding \$5,000, the Contractor shall obtain at least three bids or justify a sole source award.
- (1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.
  - (2) DHCS may identify the information needed to fulfill this requirement.
  - (3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:
    - (a) A local governmental entity or the federal government,
    - (b) A State college or State university from any State,
    - (c) A Joint Powers Authority,
    - (d) An auxiliary organization of a California State University or a California community college,
    - (e) A foundation organized to support the Board of Governors of the California Community Colleges,
    - (f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,
    - (g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,
    - (h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2. View this publication at the following Internet address: <http://www.dgs.ca.gov/ols/Resources/StateContractManual.aspx>.
- b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

- (1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.
- c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of \$5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHCS.
- d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by DHCS, make copies available for approval, inspection, or audit.
- e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.
- f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.
- g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.
- h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."
- i. Unless otherwise stipulated in writing by DHCS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.
- j. Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

## 6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement shall be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

## 7. Audit and Record Retention

(Applicable to agreements in excess of \$10,000.)

- a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.
- b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction.
- c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this



Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, CCR Title 2, Section 1896).

- d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of three years from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.
  - (1) If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of three years from the date of any resulting final settlement.
  - (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.
- e. The Contractor and/or Subcontractor shall comply with the above requirements and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code § 10115.10, if applicable.
- f. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.
- g. The Contractor shall, if applicable, comply with the Single Audit Act and the audit reporting requirements set forth in OMB Circular A-133.

## 8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

## 9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

- a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.
- b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

- c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.
- d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

## 10. Intellectual Property Rights

### a. Ownership

- (1) Except where DHCS has agreed in a signed writing to accept a license, DHCS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.
- (2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.
  - (a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.
- (3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor shall not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. **Except as otherwise set forth herein, neither the Contractor nor DHCS shall give any ownership interest in or rights to its Intellectual Property to the other Party.** If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.
- (4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor shall require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.
- (5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

**b. Retained Rights / License Rights**

- (1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.
- (2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

**c. Copyright**

- (1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter into a written agreement with any such person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.
- (2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, shall include DHCS' notice of copyright, which shall read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

**d. Patent Rights**

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

**e. Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required

for Contractor's performance of this Agreement, Contractor shall obtain a license under terms acceptable to DHCS.

**f. Warranties**

(1) Contractor represents and warrants that:

- (a) It is free to enter into and fully perform this Agreement.
- (b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.
- (c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.
- (d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.
- (e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.
- (f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.
- (g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.
- (h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

**g. Intellectual Property Indemnity**

- (1) Contractor shall indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by

Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

- (2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS shall be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.
- (3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS shall be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

#### **h. Federal Funding**

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

#### **i. Survival**

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

### **11. Air or Water Pollution Requirements**

Any federally funded agreement and/or subcontract in excess of \$100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5.

- a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).
- b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

### **12. Prior Approval of Training Seminars, Workshops or Conferences**

Contractor shall obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.



### 13. Confidentiality of Information

- a. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.
- b. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.
- c. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.
- d. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.
- e. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.
- f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

### 14. Documents, Publications and Written Reports

(Applicable to agreements over \$5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds \$5,000.

### 15. Dispute Resolution Process

- a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.
  - (1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.
  - (2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal shall be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's

decision. The Deputy Director of the division in which the branch is organized or his/her designee shall meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee shall be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

- b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code Section 100171.
- c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence shall be directed to the DHCS Program Contract Manager.
- d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor shall be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

## 16. Financial and Compliance Audit Requirements

- a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.
- b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts shall not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).
- c. The Contractor, as indicated below, agrees to obtain one of the following audits:
  - (1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040) and receives \$25,000 or more from any State agency under a direct service contract or agreement;*** the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**
  - (2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040) and receives less than \$25,000 per year from any State agency under a direct service contract or agreement,*** the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**
  - (3) ***If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by the Federal Office of Management and Budget [OMB] Circular A-133) and expends \$500,000 or more in Federal awards,*** the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133 entitled "Audits of States, Local Governments, and Non-Profit Organizations". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:
    - (a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or
    - (b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.

- (4) If the Contractor submits to DHCS a report of an audit other than an OMB A-133 audit, the Contractor must also submit a certification indicating the Contractor has not expended \$500,000 or more in federal funds for the year covered by the audit report.
- d. Two copies of the audit report shall be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager shall forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.
  - e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.
  - f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.
  - g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.
  - h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.
  - i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.
  - j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.
  - k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

## 17. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.



## 18. Novation Requirements

If the Contractor proposes any novation agreement, DHCS shall act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

## 19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

- a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR Part 3017, 45 CFR 76, 40 CFR 32 or 34 CFR 85.
- b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:
  - (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
  - (2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
  - (3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and
  - (4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.
  - (5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
  - (6) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS Program Contract Manager.
- d. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.
- e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

## 20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

- a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.
- b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.
- c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.
- d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

## 21. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

## 22. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or \$3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

## 23. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

**24. Officials Not to Benefit**

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

**25. Four-Digit Date Compliance**

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

**26. Prohibited Use of State Funds for Software**

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

**27. Use of Small, Minority Owned and Women's Businesses**

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

- (1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.
- (2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.
- (3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.
- (4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.
- (5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

**28. Alien Ineligibility Certification**

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

**29. Union Organizing**

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

- a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.
- b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.
- c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.
- d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

**30. Contract Uniformity (Fringe Benefit Allowability)**

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

- a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.
- b. As used herein, fringe benefits do not include:
  - (1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
  - (2) Director's and executive committee member's fees.
  - (3) Incentive awards and/or bonus incentive pay.
  - (4) Allowances for off-site pay.
  - (5) Location allowances.
  - (6) Hardship pay.
  - (7) Cost-of-living differentials
- c. Specific allowable fringe benefits include:
  - (1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.
- d. To be an allowable fringe benefit, the cost must meet the following criteria:
  - (1) Be necessary and reasonable for the performance of the Agreement.
  - (2) Be determined in accordance with generally accepted accounting principles.
  - (3) Be consistent with policies that apply uniformly to all activities of the Contractor.
- e. Contractor agrees that all fringe benefits shall be at actual cost.

## f. Earned/Accrued Compensation

- (1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.
- (2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.
- (3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

**31. Suspension or Stop Work Notification**

- a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.
- b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification shall remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.
  - (1) Upon receipt of a suspension or stop work notification, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.
  - (2) Within 90 days of the issuance of a suspension or stop work notification, DHCS shall either:
    - (a) Cancel, extend, or modify the suspension or stop work notification; or
    - (b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

- c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.
- d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.
- e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS shall allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.
- f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

### 32. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of \$100,000 per Section 1352 of the 31, U.S.C.)

#### a. Certification and Disclosure Requirements

- (1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds \$100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.
- (2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.
- (3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:
  - (a) A cumulative increase of \$25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;
  - (b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or
  - (c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.
- (4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding \$100,000 at any tier under a contract or agreement, or grant shall file a certification, and a disclosure form, if required, to the next tier above.
- (5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.



**Attachment 1  
State of California  
Department of Health Care Services**

**CERTIFICATION REGARDING LOBBYING**

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of \$100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

San Francisco Community Behavioral Health  
Services  
\_\_\_\_\_  
Name of Contractor

Kavoos Ghane Bassiri  
\_\_\_\_\_  
Printed Name of Person Signing for Contractor

17-94609  
\_\_\_\_\_  
Contract / Grant Number

\_\_\_\_\_  
Signature of Person Signing for Contractor

\_\_\_\_\_  
Date

Director  
\_\_\_\_\_  
Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services  
Mental Health Services Division/Program Policy Unit  
Attn: Dee Taylor  
1500 Capitol Avenue, MS 2702  
P.O. Box Number 997413  
Sacramento, CA 95899-7413

DHCS reserves the right to notify the contractor in writing of an alternate submission address.



Attachment 2

**CERTIFICATION REGARDING LOBBYING**

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure)

Approved by OMB  
0348-0046

<p>1. Type of Federal Action:</p> <p><input type="checkbox"/> a. contract</p> <p><input type="checkbox"/> b. grant</p> <p><input type="checkbox"/> c. cooperative agreement</p> <p><input type="checkbox"/> d. loan</p> <p><input type="checkbox"/> e. loan guarantee</p> <p><input type="checkbox"/> f. loan insurance</p>	<p>2. Status of Federal Action:</p> <p><input type="checkbox"/> a. bid/offer/application</p> <p><input type="checkbox"/> b. initial award</p> <p><input type="checkbox"/> c. post-award</p>	<p>3. Report Type:</p> <p><input type="checkbox"/> a. initial filing</p> <p><input type="checkbox"/> b. material change</p> <p>For Material Change Only:</p> <p>Year ____ quarter ____</p> <p>date of last report ____.</p>
<p>4. Name and Address of Reporting Entity:</p> <p><input type="checkbox"/> Prime <input type="checkbox"/> Subawardee</p> <p>Tier ____, if known:</p> <p>Congressional District, If known:</p>	<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</p> <p>Congressional District, If known:</p>	
<p>6. Federal Department/Agency</p>	<p>7. Federal Program Name/Description:</p> <p>CDFA Number, if applicable: ____</p>	
<p>8. Federal Action Number, if known:</p>	<p>9. Award Amount, if known:</p> <p>\$</p>	
<p>10.a. Name and Address of Lobbying Registrant (If individual, last name, first name, MI):</p>	<p>b. Individuals Performing Services (including address if different from 10a. (Last name, First name, MI):</p>	
<p>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than \$100,000 for each such failure.</p>	<p>Signature: _____</p> <p>Print Name: _____</p> <p>Title: _____</p> <p>Telephone No.: _____ Date: _____</p>	
<p><b>Federal Use Only</b></p>		<p>Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)</p>

**INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
 (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

CCC 04/2017

**CERTIFICATION**

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

<i>Contractor/Bidder Firm Name (Printed)</i> <i>San Francisco Community Behavioral Health Services</i>		<i>Federal ID Number</i> <i>94-6000417</i>
<i>By (Authorized Signature)</i>		
<i>Printed Name and Title of Person Signing</i> <i>Kavoos Ghane Bassiri, LMFT, Director</i>		
<i>Date Executed</i>	<i>Executed in the County of</i> <i>San Francisco</i>	

**CONTRACTOR CERTIFICATION CLAUSES**

1. **STATEMENT OF COMPLIANCE:** Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. **DRUG-FREE WORKPLACE REQUIREMENTS:** Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

- 1) the dangers of drug abuse in the workplace;
- 2) the person's or organization's policy of maintaining a drug-free workplace;
- 3) any available counseling, rehabilitation and employee assistance programs; and,
- 4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

- 1) receive a copy of the company's drug-free workplace policy statement; and,
- 2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the

certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES \$50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at [www.dir.ca.gov](http://www.dir.ca.gov), and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations,

or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

## **DOING BUSINESS WITH THE STATE OF CALIFORNIA**

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

**Exhibit A A1  
SCOPE OF WORK**

**1. Service Overview**

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 Francisco 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:

<p><b>Department of Health Care Services</b> Erika Cristo Telephone: (916) 713-8546 Email: <a href="mailto:Erika.Cristo@dhcs.ca.gov">Erika.Cristo@dhcs.ca.gov</a></p>	<p><b>San Francisco Community Behavioral Health Services</b> Hillary Kunins, MD, Behavioral Health Director Telephone: 415-255-3440 Fax: 415-255-3567 Email: <a href="mailto:hillary.kunins@sfdph.org">hillary.kunins@sfdph.org</a></p>
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B. Direct all inquiries to:

<p><b>Department of Health Care Services</b> Medi-Cal Behavioral Health Division Attention: Dee Taylor 1501 Capitol Avenue, MS 2702 Sacramento, CA, 95814 Telephone: (916) 713-8509 Email: <a href="mailto:Dee.Taylor@dhcs.ca.gov">Dee.Taylor@dhcs.ca.gov</a></p>	<p><b>San Francisco Community Behavioral Health Services</b> Attention: Hillary Kunins, MD 1380 Howard St. San Francisco, CA 94103 Telephone: 415-255-3440 Fax: 415-255-3567 Email: <a href="mailto:hillary.kunins@sfdph.org">hillary.kunins@sfdph.org</a></p>
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**Exhibit A A1**  
**SCOPE OF WORK**

- 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 §147267. 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 Francisco Community Behavioral Health Services agrees to operate the Mental Health Plan (MHP) for San Francisco 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. ~~Americans with Disabilities Act~~ Electronic and IT Accessibility Requirements Under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990**

Contractor agrees to ensure that deliverables developed and produced pursuant to this Agreement shall comply with the accessibility requirements of Sections **7405 and 11135 of the California Government Code**, Section 508 of the Rehabilitation Act **of 1973** ~~and the Americans with Disabilities 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 (42 U.S.C. § 12101 et seq.)**. 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 sections **7405 and 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 14 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); ~~42 U.S.C. § 1320c-5.~~)
- 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, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. 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. § ~~483~~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.

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- 8) Provisions for full and partial revocation of the subcontract, delegated activities or obligations, or application of other remedies permitted by state or federal law when the Department or the Contractor determine that the subcontractor has not performed satisfactorily. (42 C.F.R. § 438.230(c)(1)(iii).)
- 9) The nondiscrimination and compliance provisions of this contract as ~~described in Exhibit E, Section 5, Paragraph C and Section 6, Paragraph C.~~
- 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)~~3(h).) 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, then. (42 C.F.R. § 438.230(c)(3)(iv).)
- 11) The Department's inspection shall occur at the subcontractor's place of business, premises or physical facilities, in a form maintained 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.

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- 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. 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).)

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- C. No public officials at any level of local government shall make, participate in making, or attempt to use their official positions to influence a decision made within the scope of this Contract in which they know or have reason to know that they have a financial interest. (Gov. Code §§ 87100, 87103; Cal. Code Regs., tit. 2, § 18704; 42 C.F.R. §§ 438.3(f)(2).)
- 1) If a public official determines not to act on a matter due to a conflict of interest within the scope of this Contract, the Contractor shall notify the Department by oral or written disclosure. (Cal. Code Regs., tit. 2, § 18707; 42 C.F.R. § 438.3(f)(2).)
  - 2) Public officials, as defined in Government Code section 87200, shall follow the applicable requirements for disclosure of a conflict of interest or potential conflict of interest, once it is identified, and recuse themselves from discussing or otherwise acting upon the matter. (Gov. Code § 87105, Cal. Code Regs., tit. 2, § 18707(a); 42 C.F.R. § 438.3(f)(2).)
- D. 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) Contractor shall submit documentation to the Department of employees (current and former State employees) who may present a conflict of interest.

**Exhibit A – Attachment 2 A1  
SCOPE OF SERVICES**

**1. Provision of Services**

A. The Contractor shall provide or arrange, and pay for, the following medically necessary covered **specialty mental health services** to beneficiaries, as defined for the purposes of this contract, of San Francisco County. **See Exhibit E, Attachment 2, Service Definitions, for detailed descriptions of the specialty mental health services SMHS-listed below:**

- 1) Mental health services;
- 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; ~~and~~

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SCOPE OF SERVICES**

- 15) Targeted Case Management; **and**
- 16) **For beneficiaries under 21 years of age, 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)).**

See Exhibit E, Attachment 2, Service Definitions for detailed descriptions of the SMHS listed above.

- 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). Contractor is only required to provide inpatient and outpatient specialty mental health services, as provided for in this Contract, 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 medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary. **Any Medi-Cal services not covered by the scope of this contract will be provided through other Medi-Cal delivery systems.**
- D. The Contractor shall ensure that all medically necessary covered **s**pecialty **m**ental **h**ealth **s**ervices are sufficient in amount, duration, or 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 **s**pecialty **m**ental **h**ealth **s**ervice solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in the California Code of Regulations, title 9, sections 1820.205, 1830.205, and 1830.210. (42 C.F.R. § 438.210(a)(2) and (3).)
- E. The Contractor shall make all medically necessary covered **s**pecialty **m**ental **h**ealth **s**ervices available in accordance with California Code of



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Regulations., title 9, sections 1810.345, 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 medical necessity criteria, the contractor shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (Cal. Code Regs., tit. 9, § 1810.405(e).)
- G. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with California Code of Regulations., title 9, section 1830.225 and 42 Code of Federal Regulations part 438.3(l).
- ~~H. In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor shall not exclude a beneficiary solely on the ground that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.~~

**2. Requirements for Day Treatment Intensive and Day Rehabilitation**

- A. The Contractor shall require providers to request payment **prior** authorization for day treatment intensive and day rehabilitation services, **in accordance with Information Notice 19-026 and any subsequent departmental notices.**
  - ~~1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.~~
  - ~~2) At least every three months for continuation of day treatment intensive.~~
  - ~~3) At least every six months for continuation of day rehabilitation.~~

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- ~~4) Contractor shall also require providers to request authorization for mental health services, as defined in California Code of Regulations, title 9, section 1810.227, provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in California Code of Regulations, title 9, sections 1810.216 and 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.~~
- ~~B. The Contractor shall not delegate the payment authorization function to providers. When the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the payment authorization function does not include staff involved in the provision of day treatment intensive, day rehabilitation services, or mental health services provided concurrent to day treatment intensive or day rehabilitation services.~~
- B. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of California Code of Regulations, title 9, sections §§ 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) Community meetings. These meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic milieu, and shall actively involve staff and beneficiaries. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that beneficiaries or staff wish to discuss to elicit support of the group and conflict resolution. Community meetings shall:
    - a) For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.
    - b) For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist,

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

- 2) Therapeutic milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.
- 3) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.
- 4) Skill-building groups. In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.
- 5) Adjunctive therapies. These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the

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modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs identified in the client plan.

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 waived staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.
- 2) Mental Health Crisis Protocol. The Contractor shall ensure that there is an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.
- 3) Written Weekly Schedule. The Contractor shall ensure that a weekly detailed schedule is available to beneficiaries and as

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**SCOPE OF SERVICES**

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 California Code of Regulations, title 9, section 1840.350, for day treatment intensive, and California Code of Regulations, **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 Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.
- F. If a beneficiary is unavoidably absent and does not attend all of the scheduled hours of the day rehabilitation or day treatment intensive program, the Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day. The Contractor shall require that a separate entry be entered in the beneficiary record documenting the reason for the unavoidable absence and the total time (number of hours

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and minutes) the beneficiary actually attended the program that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

- G. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation standards described in Attachment 9 of this exhibit. The documentation shall include the date(s) of service, signature of the person providing the service (or electronic equivalent), the person's type of professional degree, licensure or job title, date of signature and the total number of minutes/hours the beneficiary actually attended the program. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist, or a registered nurse who is either staff to the day treatment intensive program or the person directing the services.
- 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

**Exhibit A – Attachment 2 A1  
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the date the provider begins delivering day treatment intensive or day rehabilitation.

- J. Additional higher or more specific standards. The Contractor shall retain the authority to set additional higher or more specific standards than those set forth in this contract, provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.
- K. 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 or operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

**3. Therapeutic Behavioral Services**

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SCOPE OF SERVICES**

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



**Exhibit A – Attachment 3 A1  
FINANCIAL REQUIREMENTS**

**1. Provider Compensation**

The Contractor shall ensure that no payment is made to a network provider other than payment the Contractor makes for services covered under this Contract, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 Code of Federal Regulations in chapter IV, or when the state agency makes direct payments to network providers for graduate medical education costs approved under the State Plan. (42 C.F.R. § 438.60.)

**2. Payments for Indian Health Care Providers**

- A. Contractor shall make payment to all Indian Health Care Providers (IHCPs) in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 §§ C.F.R. 447.454 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. Contractor shall pay an IHCP that is not enrolled as a FQHC, regardless of whether it is a network provider of the Contractor, its applicable encounter rate published annually in the Federal Register by the Indian Health Service or in the absence of a published encounter rate, the amount the IHCP would receive if the services were provided under the State plan's fee-for-service methodology. (42 C.F.R. § 438.14 (c)(2).)

**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:

**Exhibit A – Attachment 3 A1  
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**

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**the Welf. & Inst. Code § 14705(c)**, unless that date is extended by the Department, ~~in accordance with the Welf. & Inst. Code § 14705(e)~~, and/or guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the Contractor's chief financial officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to, the Contractor's chief financial officer, or (3) the Contractor's auditor-controller, or equivalent. The cost report shall include both Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual which can be accessed through the Department's Information Technology Web Services (ITWS) for the applicable year, as well as any instructions that are incorporated by reference thereto; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures developed under the Welf. & Inst. Code § 14171.

- B. In accordance with Welf. & Inst. Code § 5655, the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department, in accordance with Welf. & Inst. Code § **14197.7(o)(1)**~~14712(e)~~, may withhold payments of additional funds until the cost report that is due has been submitted.
- C. Upon receipt of an amended cost report, which includes reconciled units of service, and a certification statement that has been signed by the Contractor's Mental Health Director and one of the following: 1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county's auditor controller, or equivalent, the Department shall preliminarily settle the cost report. After completing its preliminary settlement, the Department shall so notify the Contractor if additional FFP is due to the Contractor. The Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority. If funds are due to the State,

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FINANCIAL REQUIREMENTS**

the Department shall invoice the Contractor and the Contractor shall return the overpayment to the Department.

**7. Recovery of Overpayments**

- A. The Contractor, and any subcontractor or any network provider of the Contractor, shall report to the Department within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services. (42 C.F.R. § 438.608(c)(3).)
- B. The Contractor, or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures that include provision for the suspension of payments to a network provider for which the State, or 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. (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 (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.

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- 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)(f)~~.)
- 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. **Beneficiary Liability for Payment**~~

- ~~B. The Contractor or an affiliate, vendor, contractor, or subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments. (Cal. Code Regs., tit. 9, § 1810.365 (a).)~~
- ~~C. The Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent; for costs of covered services for which~~

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FINANCIAL REQUIREMENTS**

~~the State does not pay the Contractor; for costs of covered services for which the State or the Contractor does not pay the Contractor's network providers; for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor; or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary. 42 C.F.R. § 438.106 and Cal. Code Regs. tit 9, § 1810.365(c).~~

- ~~D. The Contractor shall ensure its subcontractors and providers do not bill beneficiaries, for covered services, any amount greater than would be owed if the Contractor provided the services directly (42 C.F.R. § 483.106(c)).~~

**11. Cost Sharing**

- ~~A. The Contractor shall ensure that any cost sharing imposed on beneficiaries is in accordance with 42 Code of Federal Regulations part 447.50 through 447.82. (42 C.F.R. § 438.108.)~~
- ~~B. The Contractor shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an IHCP or through referral. (42 C.F.R. § 447.56(a)(1)(x).)~~

**10. ICD- 10**

- A. The Contractor shall use the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as the clinical tool to make diagnostic determinations.
- B. Once a DSM-5 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).
- C. 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) in accordance with the covered diagnoses for reimbursement of outpatient and inpatient Medi-Cal specialty mental

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health services listed in ~~Mental Health and Substance Use Disorder Services (MHSUDS)~~ **Behavioral Health** Information Notice **(BHIN) 17-004E20-043**.

- D. The lists of covered ICD-10 diagnosis codes in ~~MHSUDS Information Notice~~ **BHIN 17-004E20-043** are subject to change and the Department may update them during the term of this contract. Changes to the lists of covered ICD-10 covered diagnoses do not require an amendment to this contract and the Department may implement these changes via ~~Mental Health and Substance Use Disorder Services~~ Information Notices.

**Exhibit A – Attachment 4 A1  
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).)



**Exhibit A – Attachment 4 A1  
MANAGEMENT INFORMATION SYSTEMS**

- C. 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. Medi-Cal Eligibility Data System (MEDS) and MEDS Monthly Extract File (MMEF)~~**

~~The Contractor shall enter into a Medi-Cal Privacy and Security Agreement (PSA) with the Department prior to obtaining access to MEDS and the MEDS monthly extract file (MMEF). The Contractor agrees to comply with the provisions as specified in the PSA. The County Mental Health Director or his or her authorized designee shall certify annually that Contractor is in compliance with the PSA agreement. Failure to comply with the terms of the agreement will result in the termination of access to MEDS and MMEF. (42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300(a); 42 C.F.R. § 431.306(b); Welf. & Inst. Code § 14100.2(a).)~~

**Exhibit A – Attachment 5 A1  
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 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. 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 A1  
QUALITY IMPROVEMENT SYSTEM**

- 1) Surveying beneficiary/family satisfaction with the Contractor's services at least annually;
  - 2) Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
  - 3) Evaluating requests to change persons providing services at least annually.
  - 4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.
- 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. Contractor's QAPI Program shall include Performance Improvement Projects as specified in paragraph 5.

**2. Quality Improvement (QI) Work Plan**

- A. 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, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416(a);

**Exhibit A – Attachment 5 A1  
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

**Exhibit A – Attachment 5 A1**  
**QUALITY IMPROVEMENT SYSTEM**

document QI Committee meeting minutes regarding decisions and actions taken.

- 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 participation in the planning, design and execution of the QI Program** by the Contractor's practitioners and providers, ~~as well as beneficiaries~~ **who have accessed specialty mental health services through the Contractor, and family members, legal representatives, or other persons similarly involved with beneficiaries** ~~in the planning, design and execution of the QI Program,~~ as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(2)(A-C).
- F. 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;

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QUALITY IMPROVEMENT SYSTEM**

- 7) Incorporating successful interventions into the Contractor's operations as appropriate; and
- 8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

**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).)

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QUALITY IMPROVEMENT SYSTEM**

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

**6. Practice Guidelines**

- 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** ~~contracting health care professionals~~; and
  - 4) They are reviewed and updated periodically as appropriate. (42 C.F.R. § 438.236(b).)
- C. 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. 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 A1  
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 California Code of Regulations., title 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 medical necessity and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration or 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 A1  
UTILIZATION MANAGEMENT PROGRAM**

**2. Service Authorization**

- A. Contractor shall implement mechanisms to assure authorization decision standards are met **in accordance with Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 19-026, 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. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:~~

**Exhibit A – Attachment 6 A1  
UTILIZATION MANAGEMENT PROGRAM**

- ~~1) The beneficiary, or the provider, requests extension; or~~
- ~~2) The Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the beneficiary's interest. (42 C.F.R. § 438.210(d)(1))~~

**B. The Contractor shall comply with authorization timeframes in accordance with MHSUDS Information Notice 19-026, 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).)**

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) 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). The Contractor that is the MHP of the beneficiary being admitted on an emergency basis shall approve a request for payment authorization if the beneficiary meets the criteria for medical necessity and the beneficiary, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize,

**Exhibit A – Attachment 6 A1  
UTILIZATION MANAGEMENT PROGRAM**

food, shelter or clothing. (Cal Code Regs, tit. 9 §§ 1820.205 and 1820.225).

~~D. The Contractor may not require prior authorization for an emergency admission to a psychiatric health facility when the beneficiary has an emergency psychiatric condition. (Cal. Code Regs., tit. 9, §§ 1810.216 and 1830.245).~~

~~E. A Contractor shall authorize out of network services when a beneficiary with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospital services or psychiatric health facility services (Cal. Code Regs., tit. 9 §§ 1830.220, 1810.216, 1820.225, and 1830.245).~~

F. 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 A1**  
**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. **CA**, 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 medical necessity criteria for 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 medical necessity criteria for 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 medical necessity criteria for 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, or 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 A1**  
**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 California Code of Regulations, title 9, section 1810.365. (42 C.F.R. § 438.206(b)(5).)
- C. Contractor shall comply with the requirements of California Code of Regulations, title 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, 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. Procedures for ~~Serving Child Beneficiaries~~ Foster Children Placed Out-of-County**

- A. In accordance with Cal. Code Regs., tit. 9, § 1830.220 Welf. & **Inst. Code 14717.1**, the Contractor in the **foster** child's county of origin **residence** shall **be responsible to authorize, pay,** provide or arrange for medically

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necessary specialty mental health services for ~~the foster~~ children ~~in a foster care aid code~~ 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 (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 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.
- ~~E. The Contractor shall provide specialty mental health services and accept an assessment, if one exists, of needed specialty mental health services for the foster child from the MHP in the county of original jurisdiction. Nothing should preclude the Contractor from updating the assessment of conducting a new assessment if clinically indicated, but these updates or new assessments shall not delay the timely provision of specialty mental health services to the foster child.~~

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

- ~~1) Client Assessment,~~
- ~~2) Client Plan,~~
- ~~3) Service Authorization Request,~~
- ~~4) Client Assessment Update,~~
- ~~5) Progress Notes – Day Treatment Intensive Services,~~
- ~~6) Progress Notes – Day Rehabilitation Services,~~
- ~~7) Organizational Provider Agreement (Standard Contract).~~

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

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

- A. The Contractor shall ensure that the MHP in the child's adoptive parents' county of residence provides **or arrange for the provision of** medically necessary specialty mental health services to a child in an ~~an~~**the** Adoption Assistance Program (AAP) aid code residing **within their adoptive parents' county of residence in the Contractor's county. These services are to be provided** outside his or her county of origin in the same way as the MHP ~~Contractor~~**Contractor** would provide services to any **other** in-county child for whom the MHP ~~Contractor county~~**Contractor 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 MHP in the child's legal guardians' county of residence ~~The~~**Contractor** shall provide **or arrange for the provision of** medically

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necessary specialty mental health services to a child in ~~the a-Kinship-~~**Guardian Assistance Program (Kin-GAP) aid code residing within their legal guardian's county of residence in the Contractor's county.** ~~These services are to be provided outside his or her county of origin in~~ the same way that ~~the Contractor~~ would provide services to any other child for whom the ~~MHP~~**Contractor county** is listed as the county of responsibility ~~in~~**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 19-026 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 19-026 and any applicable Departmental notices issued after the effective date of this contract,** when processing or submitting authorization requests for children in a foster care AAP, or Kinship Guardian Assistance Payment (Kin-GAP,) aid code living outside his or her **their** county of origin.
- E. ~~The Contractor shall use the standard forms issued by the Department, or the electronic equivalent of those forms generated from the Contractor's Electronic Health Record System, when a child in a foster care aid code is placed outside of his/her county of origin. The standard forms are:~~
- ~~1) Client Assessment,~~
  - ~~2) Client Plan,~~
  - ~~3) Service Authorization Request,~~
  - ~~4) Client Assessment Update,~~
  - ~~5) Progress Notes – Day Treatment Intensive Services,~~



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- ~~6) Progress Notes – Day Rehabilitation Services,~~  
~~7) Organizational Provider Agreement (Standard Contract).~~

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

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

**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 his or her 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).) **Contractor shall document good-faith efforts to contract with all IHCPs in Contractor's county. If Contractor does not contract with a IHCP in Contractor's county, Contractor must submit a written explanation to the Department of why it failed to contract with that IHCP, with supporting documentation.** 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).)

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**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

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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 20-023 and its attachments, or in subsequent guidance issued in BHINs** developed 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~~ **must** submit to the Department a request for **an** Alternate Access Standards **upon notification that the Contractor is deficient in network adequacy standards**. The Department will evaluate requests and grant appropriate exceptions to the state developed standards, **as specified in BHIN 20-023 and its attachments, or in subsequent guidance issued by BHINs by the Department.** (42 C.F.R. § 438.68(a), (d), 438.206(a); **Welf. & Inst. Code § 14197.**)
- E. **The Contractor shall comply with network adequacy standards developed by the Department to implement 42 C.F.R. §§ 438.68, 438.206, and 438.207, including provider ratios and other network capacity requirements, as specified in BHIN 20-023 and its attachments, or in subsequent guidance issued by BHIN by the Department.**
4. **Timely Access**
- A. Timely Access. In accordance with 42 C.F.R. § 438.206(c)(1), the Contractor shall: ~~comply with the requirements set forth in Cal. Code Regs., tit. 9, §1810.405, including the following:~~
- 1) Meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services, **pursuant to Welf. & Inst. Code section 14197(d), as specified in BHIN 20-023 and its attachments, or in subsequent, guidance issued by the Department.**
  - 2) Comply with the timeliness standards specified in California Code of Regulations., tit. 9, section 1810.405(c) and Welf. & Inst. Code §

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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**.
- 8) ~~The timeliness standards specified in California Code of Regulations, **tit. 9**, section 1810.405 and Welf. Inst. Code § 14717.1 apply to out-of-plan services, as well as in-plan services.~~

**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 20-023 and its attachments, or in subsequent guidance issued by the Department.** ~~the network adequacy standards developed by the Department as required by departmental guidance and regulation. (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 20-023 and its attachments, or in subsequent guidance issued by the Department** in a format specified by the

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~~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).)

C. The Contractor shall submit the documentation at **the times** as specified **in BHIN 20-023 and its attachments, 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 MHP's operations that would affect the capacity and services, including changes in Contractor services, benefits, geographic service area, composition of, or payments to its provider network; or enrollment of a new population. 42 C.F.R. § 438.207(c)(3)(i)(ii)** : ~~At any time there has been a significant change, as defined by the Department, in Contractor's operations that would affect the adequacy and capacity of services, including the following:~~
  - ~~a) A decrease of 25 percent or more in services or providers available to beneficiaries;~~
  - ~~b) Changes in benefits;~~
  - ~~c) Changes in geographic service area;~~
  - d) **Changes in the** ~~Composition of or payments to Contractor's provider network; or~~

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

**f) 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 Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

**6. Choice of Provider**

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. 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 his or her

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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;
  - 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, 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. Contractor shall only use licensed, registered, or waived 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).)

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**8. Provider Certification**

- A. The Contractor shall comply with California Code of Regulations, title 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.
- 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 California Code of Regulations, title 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 California Code of Regulations, title 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



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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.
  - 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,

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as described in California Code of Regulations., title 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 California Code of Regulations., title 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.

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- 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 2 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 2 of this exhibit.
- J. On-site review is not required for hospital outpatient departments which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.
- K. On-site review is not required for primary care and psychological clinics, as defined in Health and Safety Code section 1204.1 and licensed under the Health and Safety Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license.
- L. When on-site review of an organizational provider is required, the Contractor or the Department, as applicable, shall conduct an on-site review at least once every three years. Additional certification reviews of organizational providers may be conducted by the Contractor or Department, as applicable, at its discretion, if:
  - 1) The provider makes major staffing changes.
  - 2) The provider makes organizational and/or corporate structure changes (example: conversion to non-profit status).
  - 3) The provider adds day treatment or medication support services when medications are administered or dispensed from the provider site.
  - 4) There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

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- 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.

**9. Provider Beneficiary Communications**

- A. The Contractor shall not prohibit nor otherwise restrict, a licensed, waived, or registered professional, as defined in California Code of Regulations, title 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

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- 4) The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (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 fair 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 fair hearing after the Contractor has made a determination on a beneficiary's appeal, which is adverse to the beneficiary.
  - 5) The beneficiary's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or state fair 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 fair hearing is pending if the final decision is adverse to the beneficiary.

## **Exhibit A – Attachment 9 A1 DOCUMENTATION REQUIREMENTS**

### **1. Documentation Standards**

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

#### **A. Assessment**

- 1) The Contractor shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed. For children or certain other beneficiaries unable to provide a history, this information may be obtained from the parents/care-givers, etc.
  - a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information;
  - b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
  - c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

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- d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
- e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
- f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
- g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
- i) A mental status examination;
- j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,
- k) Additional clarifying formulation information, as needed.

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

**B. Client Plans**

- 1) The Contractor shall ensure that Client Plans:
- a) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
  - b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided;
  - c) Have a proposed frequency and duration of intervention(s);
  - d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b)); have interventions that are consistent with the client plan goal;
  - e) Be consistent with the qualifying diagnoses;
  - f) Be signed (or electronic equivalent) by:
    - i. The person providing the service(s), or,
    - ii. A person representing a team or program providing services, or
    - iii. A person representing the Contractor providing services; or
    - iv. By one of the following as a co-signer, if the client plan is used to establish that services are provided under the



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direction of an approved category of staff, and if the signing staff is not of the approved category:

- a) A physician,
  - b) A licensed/waivered psychologist,
  - c) A licensed/registered/waivered social worker,
  - d) A licensed/registered/waivered marriage and family therapist, or
  - e) A registered nurse, including but not limited to nurse practitioners, and clinical nurse specialists.
- g) Include documentation of the beneficiary's participation in and agreement with the client plan, as described in Cal. Code Regs., tit. 9, § 1810.440(c)(2)(A)(B).
- i. Examples of acceptable documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary signature on the plan, or a description of the beneficiary's participation and agreement in the client record;
  - ii. The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:
    - a) The beneficiary is expected to be in long term treatment as determined by the MHP and,
    - b) The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service;

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- iii. When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.
- 2) There shall be documentation in the client plan that a copy of the client plan was offered to the beneficiary.
- 3) The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition.

C. Progress Notes

- 1) The Contractor shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:
  - a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
  - b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
  - c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;
  - d) The date the services were provided;
  - e) Documentation of referrals to community resources and other agencies, when appropriate;
  - f) Documentation of follow-up care, or as appropriate, a discharge summary; and

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DOCUMENTATION REQUIREMENTS**

- g) The amount of time taken to provide services; and
  - h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title.
- 2) Timeliness/Frequency of Progress Notes. Progress notes shall be documented at the frequency by type of service indicated below:
- a) Every Service Contact:
    - i. Mental Health Services;
    - ii. Medication Support Services;
    - iii. Crisis Intervention;
    - iv. Targeted Case Management;
  - b) Daily:
    - i. Crisis Residential;
    - ii. Crisis Stabilization (1x/23hr);
    - iii. Day Treatment Intensive; and
  - c) Weekly:
    - i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
    - ii. Day Rehabilitation;
    - iii. Adult Residential.

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D. Other

- 1) All entries to the beneficiary record shall be legible.
- 2) All entries in the beneficiary record shall include:
  - a) The date of service;
  - b) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.
  - c) The date the documentation was entered in the beneficiary record.
- 3) The Contractor shall have a written definition of what constitutes a long term care beneficiary.
- 4) Contractor shall require providers to obtain and retain a written medication consent form signed by the beneficiary agreeing to the administration of psychiatric medication. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to beneficiaries taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the beneficiary.

**Exhibit A – Attachment 10 A1  
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 his or her 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).)

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COORDINATION AND CONTINUITY OF CARE**

- B. 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 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. (Cal. Code Regs., tit. 9, § 1810.370.)
- C. 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** ~~and complies with the Department's transition of care policy.~~ (42 C.F.R. § 438.62(b)(1)-(2).)

**Exhibit A – Attachment 11 A1  
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;

**Exhibit A – Attachment 11 A1  
INFORMATION REQUIREMENTS**

- 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



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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, ~~within 15 calendar days after receipt or issuance of the termination notice~~, 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, ~~including large print~~, upon request of the potential beneficiary or beneficiary at no cost. ~~Large print means printed in a font size no smaller than 18 point.~~ **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 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 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

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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).)

~~2) The Contractor shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (42 C.F.R. § 438.10(d)(2).)~~

~~3) The Contractor shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit. (42 C.F.R. § 438.10(d)(3).)~~

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

5) 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).) 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** is available **free of charge** and how to access **these**

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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 all 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,**

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**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:
  - 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).)

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- 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 fair 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;

**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.**

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- 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 fair 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 fair 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 fair 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 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:

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- 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 California Code of Regulations, title 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.

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**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, waived, or registered mental health provider employed by the Contractor, each provider organization or individual practitioner contracting with the Contractor, and each licensed, waived, 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, ~~and whether the provider has completed cultural competence training.~~ (42 C.F.R. § 438.10(h)(1)(vii).)
  - 4) Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment. (42 C.F.R. § 438.10(h)(1)(viii).)
  - 5) A means to identify which providers are accepting new beneficiaries. (42 C.F.R. § 438.10(h)(1)(vi).)



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- 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. **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).)
- 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

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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, California Code of Regulations, title 9, sections 862 through 868, and 42 Code of Federal Regulations section 438.100. The Contractor shall ensure that its subcontractors comply with all applicable patients' rights laws and regulations.
- B. The Contractor shall have written policies regarding the 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 his or her 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 his or her health care, including the right to refuse treatment. (42 C.F.R. § 438.100(b)(2)(iv).)
  - 5) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. (42 C.F.R. § 438.100(b)(2)(v).)
  - 6) Request and receive a copy of his or her 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.)

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- 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 his or her rights without adversely affecting the way the, Contractor, subcontractor, or provider treats the beneficiary. (42 C.F.R. § 438.100(c).)

**Exhibit A – Attachment 12 A1  
BENEFICIARY PROBLEM RESOLUTION**

**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 fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of adverse benefit determination. For the purposes of this Section, a Contractor provider site means

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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 fair 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 fair 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-**

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**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 fair 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

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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).)

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- 16) The Contractor shall provide the beneficiary and his or her 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 his or her 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



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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).)

- 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).)

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- 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. Contractor's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees 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 he or she could not be contacted. (Cal. Code Regs., tit. 9, § 1850.206(c).)

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- 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:**

- 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.**

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- 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).);

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- 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** ~~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); 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. Contractor's written notice of extension shall inform the beneficiary of the right to file a grievance if he or she disagrees with the Contractor's decision. 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 his or her 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 his or her representative the beneficiary's case file free of charge and sufficiently in advance of the resolution timeframe for standard appeal resolutions. For

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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, his or her 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 his or her 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 fair hearing and the procedure for requesting a fair hearing, if the beneficiary has not already requested a fair 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 fair 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 he or she may be liable for the cost of any continued benefits if the Contractor's adverse

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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:
- 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



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extend this timeframe by up to 14 calendar days if the beneficiary requests an extension, or the Contractor **demonstrates** ~~determines~~, **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 his or her 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 his or her 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 he or she disagrees with the decision. (42 C.F.R. § 438.410(c)(2); 42 C.F.R. §



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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 Fair Hearing**

State “Fair Hearing” means the State hearing provided to beneficiaries pursuant to sections 50951 and 50953 of Title 22 of the California Code of Regulations ~~section~~ and section 1810.216.6 of Title 9 of the California Code of Regulations 1810.216.6.:

A. If a beneficiary requests a State Fair Hearing, the Department shall grant the request. (42 C.F.R. § 431.220(a)(5).) The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or Notice of 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 Fair 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 fair 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 Fair 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 Fair Hearing**

“Expedited Fair Hearing” means a fair hearing, used when the Contractor determines, or the beneficiary or the beneficiary’s provider certifies that following the 90 day timeframe for a fair hearing as established in 42 C.F.R. § 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to

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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 fair 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).)
  - 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 fair hearing is pending, the benefits must be continued until the beneficiary withdraws the appeal or request for state

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fair hearing, the beneficiary does not request a state fair 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 fair 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 fair hearing was pending if the final resolution of the appeal or state fair 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 fair 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).)

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- 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).)
- 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 California Code of Regulations, 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 California Code of Regulations, tit. 9, 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 Contractor payment authorization for a specialty mental health service that

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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).)
- 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 medical necessity criteria in sections 1830.205(b)(1),(b)(2),(b)(3)(C), or 1830.210(a) of Title 9 of the California Code of Regulations 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).)

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- 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.

**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 medical necessity criteria, 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).)

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- 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 fair 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 fair hearing or an expedited fair hearing, including:
    - a) The method by which a hearing may be obtained; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(A).)
    - b) A statement that the 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 fair hearing is requested; (Cal. Code Regs., tit. 9, § 1850.212(a)(5)(C).) and
    - d) The time limits for requesting a fair hearing or an expedited fair 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



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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).)
- 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,



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- 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 his or her 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 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

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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 he or she is ineligible for further services; (42 C.F.R. § 431.213(c).)
- 4) The beneficiary's whereabouts are unknown and mail directed to him or her 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).)
- 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 NF 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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**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

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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).)

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**4. Fraud Reporting Requirements**

- A. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to the Department about the following:
- 1) Any potential fraud, waste, or abuse. (42 C.F.R. §438.608(a), (a)(7).)
  - 2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. §438.608(a), (a)(2).)
  - 3) Information about changes in a 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).)

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- 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).)

**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. §

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455.101. For purposes of this disclosure, Contractor may use the business address for any member of its Board of Supervisors.

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

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- 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, 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 – 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.



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

**C. Disclosures Related to Persons Convicted of Crimes**

- 1) 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 A1 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

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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.)

- 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

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

- 1) Enrollment and disenrollment data;
- 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.

**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 B A1**  
**BUDGET DETAIL AND PAYMENT PROVISIONS**

**1. Payment Provisions**

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

**2. Budget Contingency Clause**

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

**A. Federal Budget**

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

**B. Delayed Federal Funding**

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

**3. Federal Financial Participation**

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

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**BUDGET DETAIL AND PAYMENT PROVISIONS**

**4. Audits and Recovery of Overpayments**

- A. Pursuant to Welf. & Inst. Code § 14707, in the case of federal audit exceptions, the Department will follow federal audit appeal processes unless the Department, in consultation with the California Mental Health Director's Association, determines that those appeals are not cost beneficial.
- 1) Whenever there is a final federal audit exception against the State resulting from a claim for federal funds for an expenditure by individual counties that is not federally allowable, the department may offset federal reimbursement and request the Controller's office to offset the distribution of funds to the Contractor from the Mental Health Subaccount, the Mental Health Equity Subaccount and the Vehicle License Collection Account of the Local Revenue Fund; funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011; and any other mental health realignment funds from which the Controller makes distributions to the counties by the amount of the exception. The Department shall provide evidence to the Controller that the county had been notified of the amount of the audit exception no less than 30 days before the offset is to occur.
  - 2) The Department will involve the Contractor in developing responses to any draft federal audit reports that directly impact the county.
- B. Pursuant to Welf. & Inst. Code § 14718(b)(2), the Department may offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the Contractor.
- 1) The Department may offset the amount of any state disallowance, audit exception, or overpayment for fiscal years through and including 2010-11 against subsequent claims from the Contractor.
  - 2) Offsets may be done at any time, after the department has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the mental health plan.
  - 3) The maximum withheld amount shall be 25 percent of each payment as long as the Department is able to comply with the federal requirements for repayment of FFP pursuant 42 United States Code (U.S.C.) §1396b(d)(2)).

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The Department may increase the maximum amount when necessary for compliance with federal laws and regulations.

- C. Pursuant to the Welf. & Inst. Code § 14170, cost reports submitted to the Department are subject to audit in the manner and form prescribed by the Department. The year-end cost report shall include both Contractor's costs and the costs of its subcontractors, if any. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. In accordance with the Welf. & Inst. Code § 14170, any audit of Contractor's cost report shall occur within three years of the date of receipt by the Department of the final cost report with signed certification by the Contractor's Mental Health Director and one of the following: (1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county auditor controller, or equivalent. Both signatures are required before the cost report shall be considered final. For purposes of this section, the cost report shall be considered audited once the Department has informed the Contractor of its intent to disallow costs on the cost report, or once the Department has informed the Contractor of its intent to close the audit without disallowances.
- D. If the adjustments result in the Department owing FFP to the Contractor, the Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority.

**5. Claims Adjudication Process**

- A. In accordance with the Welf. & Inst. Code §14705(c), claims for federal funds in reimbursement for services shall comply with eligibility and service requirements under applicable federal and state law.
- B. The Contractor shall certify each claim submitted to the Department in accordance with Cal. Code Regs., tit. 9, § 1840.112 and 42 C.F.R. § 433.51, at the time the claims are submitted to the Department. The Contractor's Chief Financial Officer or his or her equivalent, or an individual with authority delegated by the county auditor-controller, shall sign the certification, declaring, under penalty of perjury, that the Contractor has incurred an expenditure to cover the services included in the claims to satisfy the requirements for FFP. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification, declaring, under penalty of perjury that, to the best of his or her knowledge and belief, the claim is in all respects true, correct, and in accordance with the law and meets the requirements of Cal. Code Regs., tit. 9, § 1840.112(b). The Contractor shall have mechanisms that support the Mental

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Health Director's certification, including the certification that the services for which claims were submitted were actually provided to the beneficiary. If the Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 C.F.R. § 438.604.

- C. Claims not meeting federal and/or state requirements shall be returned to Contractor as not approved for payment, along with a reason for denial. Claims meeting all Health Insurance Portability and Accountability Act (HIPAA) transaction requirements and any other applicable federal or state privacy laws or regulations and certified by the Contractor in accordance with Cal. Code Regs., tit. 9, §1840.112, shall be processed for adjudication.
- D. Good cause justification for late claim submission is governed by applicable federal and state laws and regulations and is subject to approval by the Department.
- E. In the event that the Department or the Contractor determines that changes requiring a change in the Contractor's or Department's obligation must be made relating to either the Department's or the Contractor's claims submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated requirements and impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.
- F. The Contractor shall comply with Cal. Code Regs., tit. 9, § 1840.304, when submitting claims for FFP for services billed by individual or group providers. The Contractor shall submit service codes from the Health Care Procedure Coding System (HCPCS) published in the most current Mental Health Medi-Cal billing manual.

**6. Payment Data Certification**

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

**7. System Changes**

In the event changes in federal or state law or regulations, including court decisions and interpretations, necessitate a change in either the fiscal or program obligations or



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

**8. Administrative Reimbursement**

- A. The Contractor may submit claims for reimbursement of Medical Administrative Activities (MAA) pursuant to Welf. & Inst. Code § 14132.47. The Contractor shall not submit claims for MAA unless it has submitted a claiming plan to the Department which was approved by the Department and is effective during the quarter in which the costs being claimed were incurred. In addition, the Contractor shall not submit claims for reimbursements of MAA that are not consistent with the Contractor's approved MAA claiming plan. The Contractor shall not use the relative value methodology to report its MAA costs on the year-end cost report. Rather, the Contractor shall calculate and report MAA units on the cost report by multiplying the amount of time (minutes, hours, etc.) spent on MAA activities by the salary plus benefits of the staff performing the activity and then allocating indirect administrative and other appropriately allocated costs.
- B. Pursuant to the Welf. & Inst. Code § 14711(c), administrative costs shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medicaid state plans and waivers and shall be limited to 15 percent of the total actual cost of direct client services. The cost of performing quality assurance and utilization review activities shall be reimbursed separately and shall not be included in administrative costs.

**9. Notification of Request for Contract Amendment**

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

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**1. Additional Incorporated Exhibits**

A. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit A, Attachment 9	Documentation Requirements	7 page(s)
2) Exhibit A, Attachment 10	Coordination And Continuity Of Care	2 page(s)
3) Exhibit A, Attachment 11	Information Requirements	13 pages
4) Exhibit A, Attachment 12	Beneficiary Problem Resolution	23 pages
5) Exhibit A, Attachment 13	Program Integrity	7 pages
6) Exhibit A, Attachment 14	Reporting Requirements	3 pages
7) Exhibit B	Budget Detail And Payment Provisions	5 pages
8) Exhibit C *	General Terms And Conditions	<a href="#">GTC 04/2017</a>
9) Exhibit D (F)	Special Terms And Conditions (Attached hereto as part of this agreement) (Notwithstanding Provisions 2, 3, 4, 6 ,8, 12, 14, 22, 25, 29, and 30 which do not apply to this agreement.)	27 pages
10) Exhibit E	Additional Provisions (Program Terms And Conditions)	17 pages
11) Exhibit E, Attachment 1	Definitions	5 pages
12) Exhibit E, Attachment 2	Service Definitions	6 pages
13) Exhibit F	HIPAA Business Associate Addendum	27 pages
14) Exhibit F, Attachment B	Information Security Exchange Agreement between the Social Security Administration (SSA) and the California Department of Health Care Services (DHCS)	101 pages

**2. Amendment Process**

Should either party, during the term of this Contract, desire a change or amendment to the terms of this Contract, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether

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the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

**3. Cancellation/Termination**

A. General Provisions

- 1) As required by, if the Contractor decides not to contract with the Department, does not renew its contract, or is unable to meet the standards set by the Department, the Contractor agrees to inform the Department of this decision in writing. (Welf. & Inst. Code § 14712(c)(1).)
- 2) If the Contractor is unwilling to contract for the delivery of specialty mental health services or if the Department or Contractor determines that the Contractor is unable to adequately provide specialty mental health services or that the Contractor does not meet the standards the Department deems necessary for a mental health plan, the Department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries. (Welf. & Inst. Code § 147122(c)(2), (3).)
- 3) The Department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the Department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the Department. The Contractor may not subsequently contract to provide specialty mental health services unless the Department elects to contract with the Contractor. (Welf. & Inst. Code § 147122(c)(4).)
- 4) If the Contractor does not contract with the Department to provide specialty mental health services, the Department will work with the Department of Finance and the Controller to obtain funds from the Contractor in accordance with Government (Govt.) Code 30027.10. (Welf. & Inst. Code § 147122(d).)

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**B. Contract Renewal**

- 1) This contract may be renewed if the Contractor continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. (42 C.F.R. § 438.708; Welf. & Inst. Code § 14714(b)(1).) The Department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract. (Welf. & Inst. Code § 14714(b)(1).)
- 2) In the event the contract is not renewed based on the reasons specified in (1), the Department will notify the Department of Finance, the fiscal and policy committees of the Legislature, and the Controller of the amounts to be sequestered from the Mental Health Subaccount, the Mental Health Equity Account, and the Vehicle License Fee Collection Account of the Local Revenue Fund and the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and the Controller will sequester those funds in the Behavioral Health Subaccount pursuant to Govt. Code § 30027.10. Upon this sequestration, the Department will use the funds in accordance with Govt. Code § 30027.10. (Welf. & Inst. Code § 14714(b)(3).)

**C. Contract Amendment Negotiations**

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

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change mutually agreed to by the parties on the condition that the amendment is approved by the Department of General Services, if necessary.

**D. Contract Termination**

The Department or the Contractor may terminate this contract in accordance with, and within the given timeframes provided in California Code of Regulations, title 9, section 1810.323.

- 1) DHCS reserves the right to cancel or terminate this Contract immediately for cause.
- 2) The term "for cause" shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Contract.
- 3) Contract termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor. The notice shall identify any final performance, invoicing or payment requirements.
- 4) Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel, or if cancellation is not possible reduce, subsequent contract costs.
- 5) In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Contract and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.
- 6) The Department will immediately terminate this Contract if the Department finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons will be subject to reasonable notice to the Contractor of the Department's intent to terminate, as well as notification to affected beneficiaries. (Welf. & Inst. Code § 14714(d).)

**E. Termination of Obligations**

- 1) All obligations to provide covered services under this contract shall automatically terminate on the effective date of any termination of

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this contract. The Contractor shall be responsible for providing covered services to beneficiaries until the termination or expiration of the contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to beneficiaries prior to such expiration or termination.

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

**F. Contract Disputes**

Should a dispute arise between the Contractor and the Department relating to performance under this contract, other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, California Code of Regulations, title 9, or the processes governing the audit appeals process in Chapter 9 of Division 1, California Code of Regulations, title 9 the Contractor shall follow the Dispute Resolution Process outlined in provision number 15 of Exhibit D(F) which is attached hereto as part of this contract.

**4. Fulfillment of Obligation**

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

**5. Additional Provisions**

**A. Inspection Rights/Record Keeping Requirements**

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

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- 2) The Contractor, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. Contractor shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.
- 3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract, including beneficiary grievance and appeal records identified in Attachment 12, Section 2 and the data, information and documentation specified in 42 Code of Federal Regulations parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (42 C.F.R. § 438.3(u); See also § 438.3(h).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's



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performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

**B. Notices**

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

Department of Health Care Services  
**Medi-Cal Behavioral Mental Health**  
**Services Division**  
15001 Capitol Avenue, MS 2702  
P.O. Box 997413  
Sacramento, CA 95899-7413 **95814**

San Francisco Community Behavioral  
Health Services  
1380 Howard St.  
San Francisco, CA 94103

**C. Nondiscrimination**

- 1) Consistent with the requirements of applicable federal law, such as 42 Code of Federal Regulations, part 438.3(d)(3) and (4), and state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect ~~on the basis of~~ **any ground protected under federal or state law, including sex,** race, color, gender, gender identity, religion, marital status, national origin, **ethnic group identification, ancestry,** age, sexual orientation, **medical condition, genetic information,** or mental or physical handicap or disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(~~3-4~~); 45 C.F.R. § 92.28(a)(1); Gov. Code § 11135(a); Welf. & Inst. Code § 14727(a)(3).)
- 2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended (**codified at 29 U.S.C. § 794**), ~~pertaining to the prohibition of~~ **exclusion, denial of benefits, and** discrimination against qualified ~~handicapped persons~~ **individuals with a disability** in ~~all~~ **any** federally assisted programs



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or activities, **and shall comply with the implementing regulations** as detailed in regulations **Parts 84 and 85 of Title 45 of the C.F.R., as applicable** signed by the Secretary of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977.

- 3) The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.
- 4) Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to California Code of Regulations, title 9, sections 1820.205, 1830.205 and/or 1830.210, prior to providing covered services to a beneficiary.

**D. Relationship of the Parties**

The Department and the Contractor are, and shall at all times be deemed to be, independent agencies. Each party to this contract shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this contract. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department and its agents and employees shall not be entitled to any rights or privileges of the Contractor's employees and shall not be considered in any manner to be Contractor employees. The Contractor and its agents and employees, shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

**E. Waiver of Default**

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

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**6. Duties of the State**

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

A. Payment for Services

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

B. Reviews

The Department shall conduct reviews of access to and quality of care in Contractor's county at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, pursuant to California Code of Regulations, title 9, sections 1810.380 and 1810.385. The Department shall also arrange for an annual external quality review of the Contractor as required by 42 Code of Federal Regulations, part 438.350 and California Code of Regulations, title 9, section 1810.380(a)(7).

C. Monitoring for Compliance

When monitoring activities identify areas of non-compliance, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action. (Cal. Code Reg., tit. 9, § 1810.380.) Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to Cal. Code Reg., tit. 9, § 1810.385.

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

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- E. If the Contractor has not previously implemented a Mental Health Plan or Contractor will provide or arrange for the provision of covered benefits to new eligibility groups, then the Contractor shall develop an Implementation Plan (as defined in Cal. Code Regs., tit. 9, § 1810.221) that is consistent with the readiness review requirements set forth in 42 Code of Federal Regulations, part 438.66(d)(4), and the requirements of Cal. Code Regs., tit. 9, § 1810.310 (a). (See 42 C.F.R. § 438.66(d)(1), (4).) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to the Contractor within 60 days of the receipt of the Implementation Plan. (Cal. Code Regs., tit. 9, § 1810.310(b).) A Contractor shall submit proposed changes to its approved Implementation Plan in writing to the Department for review. A Contractor shall submit proposed changes in the policies, processes or procedures that would modify the Contractor's current Implementation Plan prior to implementing the proposed changes.(See Cal. Code Regs., tit. 9, § 1810.310 (b)-(c)).
- F. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Cal. Code Regs., tit. 9, § 1810.410. The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for the disapproval, to the Contractor within 60 calendar days after receipt of the plan from the Contractor. If the Department fails to provide a Notice of Approval or Disapproval, the Contractor may implement the plan 60 calendar days from its submission to the Department.
- G. Certification of Organizational Provider Sites Owned or Operated by the Contractor
- 1) The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with California Code of Regulations., tit. 9, section 1810.435, and the requirements specified in Exhibit A, Attachment 3, Section 6 of this contract. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every three years after that date, unless the Department determines an earlier date is necessary. The on-site review required by Cal. Code Regs., tit. 9, § 1810.435(e), shall be conducted of any site owned, leased, or operated by the Contractor and used for to deliver covered services

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to beneficiaries, except that on-site review is not required for public school or satellite sites.

- 2) The Department may allow the Contractor to begin delivering covered services to beneficiaries at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained, whichever date is latest.
- 3) The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational and has all required fire clearances.
- 4) Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of FFP by the Contractor and the Department's tracking of that information.

H. Excluded Providers

- 1) If the Department learns that the Contractor has a prohibited affiliation, as described in Attachment 1, Section 2, the Department:
  - a) Must notify the Secretary of the noncompliance.
  - b) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
  - c) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

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

I. Sanctions

The Department shall conduct oversight and impose sanctions on the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations, in accordance with Welf. & Inst. Code § ~~14197.714712(e)~~ **14197.714712(e)** and Cal. Code Regs., tit. 9, §§ 1810.380 and 1810.385.

J. Notification

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

K. Performance Measurement

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

**7. State and Federal Law Governing this Contract**

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

- B. Contractor agrees to comply with all applicable federal and state law, including the applicable sections of the state plan and waiver, including but not limited to the statutes and regulations incorporated by reference below in Sections **D, G, and H, C, E, and F, and applicable sections of the state plan and waiver** in its provision of services as the Mental Health Plan. Contractor agrees to comply with any changes to these statutes and regulations that may occur during the contract period and any new applicable statutes or regulations. These obligations shall not apply without the need for a Contract amendment(s). To the extent there is a conflict between federal or state law or regulation and a provision in this

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contract, Contractor shall comply with the federal or state law or regulation and the conflicting Contract provision shall no longer be in effect.

- C. Contractor agrees to comply with all existing policy letters issued by the Department. All policy letters issued by the Department subsequent to the effective date of this Contract shall provide clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to State or federal statutes or regulations, or pursuant to judicial interpretation.
- D. Federal law:
- 1) Title 42 United States Code, to the extent that these requirements are applicable;
  - 2) 42 C.F.R. to the extent that these requirements are applicable;
  - 3) 42 C.F.R. Part 438, Medicaid Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHPs), except for the provisions listed in paragraph D and E, below.
  - 4) 42 C.F.R. § 455 to the extent that these requirements are applicable;
  - 5) **45 C.F.R. § 92.1 et seq. to the extent these requirements are applicable;**
  - 6) Title VI of the Civil Rights Act of 1964;
  - 7) Title IX of the Education Amendments of 1972;
  - 8) Age Discrimination Act of 1975;
  - 9) Rehabilitation Act of 1973;
  - 10) Americans with Disabilities Act;
  - 11) Section 1557 of the Patient Protection and Affordable Care Act;
  - 12) Deficit Reduction Act of 2005;

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ADDITIONAL PROVISIONS**

- 13) Balanced Budget Act of 1997;
- 14) The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act, which requires that all contracts and subcontracts in excess of \$2000 for construction or repair awarded by the Contractor and its subcontractors shall include a provision for compliance with the Copeland Anti-Kickback Act.
- 15) The Contractor shall comply with the provisions of the Davis-Bacon Act, as amended, which provides that, when required by Federal Medicaid program legislation, all construction contracts awarded by the Contractor and its subcontractors of more than \$2,000 shall include a provision for compliance with the Davis-Bacon Act as supplemented by Department of Labor regulations.
- 16) The Contractor shall comply with the provisions of the Contract Work Hours and Safety Standards Act, as applicable, which requires that all subcontracts awarded by the Contractor in excess of \$2,000 for construction and in excess of \$2,500 for other subcontracts that involve the employment of mechanics or laborers shall include a provision for compliance with the Contract Work Hours and Safety Standards Act.
- 17) Any applicable federal and state laws that pertain to beneficiary rights.
- 18) **Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS must adjust payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the**

**Exhibit E A1  
ADDITIONAL PROVISIONS**

**work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.**

- E. The following sections of 42 Code of Federal Regulations, part 438 are inapplicable to this Contract:
- 1) §438.3(b) Standard Contract Provisions – Entities eligible for comprehensive risk contracts
  - 2) §438.3(c) Standard Contract Provisions - Payment
  - 3) §438.3(g) Standard Contract Provisions - Provider preventable conditions
  - 4) §438.3(o) Standard Contract Provisions - LTSS contract requirements
  - 5) §438.3(p) Standard Contract Provisions – Special rules for HIOs
  - 6) §438.3(s) Standard Contract Provisions – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs
  - 7) §438.4 Actuarial Soundness
  - 8) §438.5 Rate Development Standards
  - 9) §438.6 Special Contract Provisions Related to Payment
  - 10) §438.7 Rate Certification Submission
  - 11) §438.8 Medical Loss Ratio Standards
  - 12) §438.9 Provisions that Apply to Non-emergency Medical Transportation



**Exhibit E A1  
ADDITIONAL PROVISIONS**

- 13) §438.50 State Plan Requirements
  - 14) §438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities
  - 15) §438.56 Disenrollment: requirements and limitations
  - 16) §438.70 Stakeholder engagement when LTSS is delivered through a managed care program
  - 17) 438.74 State Oversight of the Minimum MLR Requirements
  - 18) §438.104 Marketing
  - 19) **§438.106 Liability for Payment**
  - 20) **§438.108 Cost Sharing**
  - 21) §438.110 Member advisory committee
  - 22) §438.114 Emergency and Post-Stabilization
  - 23) §438.362 Exemption from External Quality Review
  - 24) §438.700-730 Basis for Imposition of Sanctions
  - 25) §438.802 Basic Requirements
  - 26) §438.810 Expenditures for Enrollment Broker Services
  - 27) §438.816 Expenditures for the beneficiary support system for enrollees using LTSS
- F. Specific provisions of 42 Code of Federal Regulations, part 438 relating to the following subjects are inapplicable to this Contract:
- 1) Long Terms Services and Supports
  - 2) Managed Long Terms Services and Supports
  - 3) Actuarially Sound Capitation Rates

**Exhibit E A1  
ADDITIONAL PROVISIONS**

- 4) Medical Loss Ratio
  - 5) Religious or Moral Objections to Delivering Services
  - 6) Family Planning Services
  - 7) Drug Formularies and Covered Outpatient Drugs
- G. Pursuant to Welf. & Inst. Code section 14704, a regulation or order concerning Medi-Cal specialty mental health services adopted by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000), as in effect preceding the effective date of this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by DHCS, or until it expires by its own terms.
- H. State Law:
- 1) Division 5, Welf. & Inst. Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 2) Welf. & Inst. Code §§ 14680-14685.1
  - 3) Welf. & Inst. Code §§ 14700-14727~~6~~
  - 4) Chapter 7, Part 3, Division 9, Welf. & Inst. Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 5) Cal. Code Regs., tit. 9, § 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services
  - 6) Cal. Code Regs., tit. 22, §§ 50951 and 50953
  - 7) Cal. Code Regs., tit. 22, §§ 51014.1 and 51014.2

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

1. The following definitions and the definitions contained in California Code of Regulations., title 9, sections 1810.100-1850.535 shall apply in this contract. If there is a conflict between the following definitions and the definitions in California Code of Regulations., title 9, sections 1810.100-1850.535, the definitions below will apply.
  - A. “Advance Directives” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the healthcare when the individual is incapacitated.
  - B. “Abuse” means, as the term described in, provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)
  - C. “Appeal” means a review by the Contractor of an adverse benefit determination.
  - D. “Beneficiary” means a Medi-Cal recipient who is currently receiving services from the Contractor.
  - E. "Contractor" means San Francisco Community Behavioral Health Services.
  - F. "Covered Specialty Mental Health Services" are defined in Exhibit E, Attachment 2.
  - G. "Department" means the California Department of Health Care Services (DHCS).
  - H. “Director” means the Director of DHCS.
  - I. **“Discrimination Grievance” means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.**

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

- J. “Emergency” means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (Health & Safety Code § 1797.07).
- K. “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes an act that constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)
- L. “Grievance” means an expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights regardless of whether remedial action is requested. Grievance includes a beneficiary’s right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400)
- M. “Habilitative services and devices” help a person keep, learn, or improve skills and functioning for daily living. (45 C.F.R. § 156.115(a)(5)(i))
- N. "HHS" means the United States Department of Health and Human Service
- ~~O. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association, or the American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)~~
- P. **“Managed Care Organization” (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. Part 438, and is: 1) a Federally qualified HMO that meets the advance directives requirements of Subpart I of Part 489 of 42 C.F.R.; or, 2) any public or private entity that meets the advance directive requirements and is determined by the Secretary of Health and Human Services to also meet the following conditions: i) makes the services that it provides to its Medicaid beneficiaries as accessible (in terms of timeliness, amount, duration, and scope) as those**

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

**services are to other Medicaid beneficiaries within the area served by the entity, ii) meet the solvency standards of 42 C.F.R. 438.116. (42 C.F.R. § 438.2)**

- Q. A “Network Provider” means any provider, group of providers, or entity that has a network provider agreement with a Mental Health Plan, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department’s contract with a Mental Health Plan. A network provider is not a subcontractor by virtue of the network provider agreement. (42 C.F.R. § 438.2)
- R. “Out-of-network provider” means a provider or group of providers that does not have a network provider agreement with a Mental Health Plan, or with a subcontractor. (A provider may be “out of network” for one Mental Health Plan, but in the network of another Mental Health Plan.)
- S. “Out-of-plan provider” has the same meaning as out-of-network provider.
- T. **“Overpayment” means any payment made to a network provider by a Mental Health Plan to which the network provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)**
- U. “Provider” means a person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.
- ~~V. “Overpayment” means any payment made to a network provider by a Mental Health Plan to which the provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)~~

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

- W. “Physician Incentive Plans” mean any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.
- X. “PIHP” means Prepaid Inpatient Health Plan. . A Prepaid Inpatient Health Plan is an entity that:
- 1) Provides medical services to beneficiaries under contract with the Department of Health Care Services, and on the basis of prepaid capitation payments, or other payment arrangement that does not use state plan rates;
  - 2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and
  - 3) Does not have a comprehensive risk contract. (42 C.F.R. § 438.2)
- Y. "Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries. (California's Medicaid State Plan, State Plan Amendment 10-016, Attachment 3.1-A, Supplement 3, p. 2a.)
- Z. “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.
- AA. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate**

**Exhibit E – Attachment 1 A1  
DEFINITIONS**

**Medical Education, the American Medical Association, or the  
American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)**

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

- 1) Any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this contract.
- 2) "Subcontractor" means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. Notwithstanding the foregoing, for purposes of Exhibit D(F) the term "subcontractor" shall include network providers.

**Exhibit E – Attachment 2 A1  
SERVICE DEFINITIONS**

1. The Contractor shall provide, or arrange and pay for, the following medically necessary covered specialty mental health services to beneficiaries of San Francisco County. Services shall be provided based on medical necessity criteria, in accordance with an individualized Client Plan, and approved and authorized according to State of California requirements. Services include:
  - A. Mental Health Services Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:
    - 1) Assessment - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.
    - 2) Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.
    - 3) Therapy - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.
    - 4) Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.
    - 5) Collateral - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited



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SERVICE DEFINITIONS**

to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

- B. Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.
- C. Day Treatment Intensive are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- D. Day Rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

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**SERVICE DEFINITIONS**

- E. Crisis Intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.
- F. Crisis Stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- G. Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- H. Crisis Residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.
- I. Psychiatric Health Facility Services—A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated

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SERVICE DEFINITIONS**

general acute care hospital or in outpatient settings. These services are separate from those categorized as “Psychiatric Inpatient Hospital”.

- J. Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the **Integrated** Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a **child** youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:
- 1) Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth-**child** driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
  - 2) Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
  - 3) Supports the parent/caregiver in meeting their child/youth’s needs;
  - 4) Helps establish the CFT and provides ongoing support; and
  - 5) Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community
- K. Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth’s functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth’s family’s ability to help the

**Exhibit E – Attachment 2 A1**  
**SERVICE DEFINITIONS**

child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the **Integrated** Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

- L. Therapeutic Behavioral Services (TBS) are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.
- M. Therapeutic Foster Care (TFC) Services model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized **specialty mental health services** SMHS activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma informed interventions that are medically necessary for the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain **specialty mental health services** SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).
- N. ~~Psychiatric Inpatient Hospital~~ Psychiatric Inpatient Hospital Services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the

**Exhibit E – Attachment 2 A1**  
**SERVICE DEFINITIONS**

hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

- O. ~~Targeted Case Management~~ Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

# Contractor Certification Clauses

CCC 04/2017

## CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
San Francisco Community Behavioral Health Service	94-6000417

By (Authorized Signature)

Printed Name and Title of Person Signing

Date Executed	Executed in the County of
	San Francisco

## CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

- 1) the dangers of drug abuse in the workplace;
- 2) the person's or organization's policy of maintaining a drug-free workplace;
- 3) any available counseling, rehabilitation and employee assistance programs; and,
- 4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

- 1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES \$50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at [www.dir.ca.gov](http://www.dir.ca.gov), and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably



required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of \$100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

## **DOING BUSINESS WITH THE STATE OF CALIFORNIA**

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and



Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.



City and County of San Francisco  
London N. Breed, Mayor

## San Francisco Department of Public Health

Grant Colfax, MD  
Director of Health

April 15, 2022

Angela Calvillo, Clerk of the Board  
Board of Supervisors  
1 Dr. Carlton B. Goodlett Place, Room 244  
San Francisco, CA 94102-4689

Dear Ms. Calvillo:

Please find attached a proposed resolution for Board of Supervisors approval of an amendment to the agreement between the Department of Public Health and the California Department of Health Care Services, in the amount of \$0.

This contract agreement requires Board of Supervisors approval under San Francisco Charter Section 9.118.

The following is a list of accompanying documents:

- Proposed resolution
- Proposed Amendment 17-94609 A01
- Original Agreement and Original Board Resolution 332-18, File No. 180829

Should you have any questions, please contact Elissa Velez, Regulatory Affairs Manager, Behavioral Health Services, Department of Public Health. Elissa may be reached at (415) 305-9792 or by email at [elissa.velez@sfdph.org](mailto:elissa.velez@sfdph.org)

Sincerely,

DocuSigned by:  
  
E4918F30E78146B...

Kelly Hiramoto  
Acting Supervisor  
Office of Contracts Management and Compliance  
DPH Business Office

cc: Dr. Grant Colfax, Director of Health  
Greg Wagner, Chief Operating Officer  
Michelle Ruggels, Director, DPH Business Office

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**The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.**

We shall ~ Assess and research the health of the community ~ Develop and enforce health policy ~ Prevent disease and injury ~  
~ Educate the public and train health care providers ~ Provide quality, comprehensive, culturally-proficient health services ~ Ensure equal access to all ~

[kellyhiramoto@SFDPH.org](mailto:kellyhiramoto@SFDPH.org) – office 415-255-3492 – fax 415 252-3088  
1380 Howard Street, Room 419B, San Francisco, CA 94103

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1 [Agreement - California Department of Health Care Services - Mental Health Plan - \$0]

2  
3 **Resolution retroactively approving Agreement No. 17-94609, between Department of**  
4 **Public Health, Community Behavioral Health Services, and the California Department of**  
5 **Health Care Services, for the San Francisco Mental Health Plan, for a five year term of**  
6 **July 1, 2017, through June 30, 2022, in the amount of \$0.**

7  
8 WHEREAS, California Welfare and Institutions (W&I) Code, Section 14712 directs the  
9 California Department of Health Care Services (DHCS) to implement and administer Managed  
10 Mental Health Care for Medi-Cal eligible residents through agreements with Mental Health  
11 Plans (MHP) in California counties; and

12 WHEREAS, MHPs are required to provide or arrange for the provision of Specialty  
13 Mental Health Services to beneficiaries in their counties that meet medical necessity criteria,  
14 consistent with the beneficiaries' mental health treatment needs and goals; and

15 WHEREAS, This Mental Health Plan Agreement sets forth the scope of service and  
16 requirements related to the provision of these services for San Francisco County; and

17 WHEREAS, The Department of Public Health, Community Behavioral Health Services  
18 (DPH-CBHS) operates the Mental Health Plan for the City and County of San Francisco; and

19 WHEREAS, The Centers for Medicare and Medicaid Services (CMS) recently  
20 promulgated revisions to the managed care regulations applicable to MHPs; and

21 WHEREAS, CMS is requiring DHCS to develop new agreements with MHPs, effective  
22 July 1, 2017, reflecting these changes as a condition of payment of federal financial  
23 participation (42 C.F.R. 438.802(a)); and

24 WHEREAS, DHCS is requiring the new MHP agreements to take effect retroactively  
25 with a term of July 1, 2017, through June 30, 2022; and

1           WHEREAS, On June 18, 2018, DHCS forwarded Agreement No. 17-94609 for the San  
2           Francisco Mental Health Plan to DPH-CBHS, for the term of July 1, 2017, through June 30,  
3           2022, on file with the Clerk of the Board of Supervisors in File No. 180715, which is hereby  
4           declared to be a part of this resolution as if set forth fully herein; now, therefore, be it

5           RESOLVED, That the DPH-CBHS is hereby authorized to retroactively enter into a  
6           Mental Health Plan Agreement No 17-94609 with DHCS; and, be it

7           FURTHER RESOLVED, That the Board of Supervisors hereby authorizes the Director  
8           of DPH-CBHS to sign said agreement on behalf of the City and County of San Francisco; and,  
9           be it

10          FURTHER RESOLVED, That within thirty (30) days of the Mental Health Plan  
11          Agreement being fully executed by all parties, the Director of DPH-CBHS shall provide the  
12          final agreement to the Clerk of the Board for inclusion in File No. 180715.



**City and County of San Francisco**  
**Tails**  
**Resolution**

City Hall  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689

**File Number:** 180715

**Date Passed:** September 04, 2018

Resolution retroactively approving Agreement No. 17-94609, between Department of Public Health, Community Behavioral Health Services, and the California Department of Health Care Services, for the San Francisco Mental Health Plan, for a five year term of July 1, 2017, through June 30, 2022, in the amount of \$0.

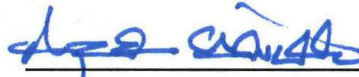
July 26, 2018 Budget and Finance Sub-Committee - RECOMMENDED

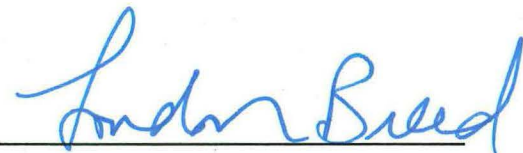
September 04, 2018 Board of Supervisors - ADOPTED

Ayes: 11 - Brown, Cohen, Fewer, Kim, Mandelman, Peskin, Ronen, Safai, Stefani, Tang and Yee

File No. 180715

I hereby certify that the foregoing  
Resolution was ADOPTED on 9/4/2018 by  
the Board of Supervisors of the City and  
County of San Francisco.

  
\_\_\_\_\_  
Angela Calvillo  
Clerk of the Board

  
\_\_\_\_\_  
London N. Breed  
Mayor

  
\_\_\_\_\_  
Date Approved



President, District 10  
BOARD of SUPERVISORS



City Hall  
1 Dr. Carlton B. Goodlett Place, Room 244  
San Francisco, CA 94102-4689  
Tel. No. 554-6516  
Fax No. 554-7674  
TDD/TTY No. 544-6546

**Shamann Walton**

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**PRESIDENTIAL ACTION**

Date: 05/12/2022

To: Angela Calvillo, Clerk of the Board of Supervisors

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Madam Clerk,  
Pursuant to Board Rules, I am hereby:

Waiving 30-Day Rule (Board Rule No. 3.23)

File No. \_\_\_\_\_

(Primary Sponsor)

Title. \_\_\_\_\_

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Transferring (Board Rule No 3.3)

File No. 220417 \_\_\_\_\_

(Primary Sponsor)

Title. Agreement Amendment - California Department of Health Care  
Services - Mental Health Plan - \$0

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From: Budget & Finance \_\_\_\_\_ Committee

To: Government Audit & Oversight \_\_\_\_\_ Committee

Assigning Temporary Committee Appointment (Board Rule No. 3.1)

Supervisor: \_\_\_\_\_ Replacing Supervisor: \_\_\_\_\_

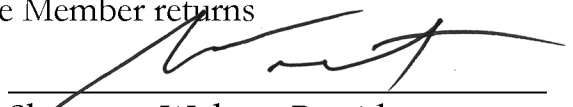
For: \_\_\_\_\_ Meeting  
(Date) (Committee)

Duration:  Partial

Full Meeting

Start Time \_\_\_\_\_ End Time \_\_\_\_\_

Until original Committee Member returns

  
\_\_\_\_\_  
Shamann Walton, President  
Board of Supervisors