County of Santa Cruz

HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE
SANTA CRUZ, CA **95061**
(831) 454-4066 FAX: (831) 454-4770

HEALTH SERVICES AGENCY
ADMINISTRATION

May 10,2004

AGENDA: June 15,2004

APPROVED AND FILED
BOARD OF SUPERVISORS
DATE: June 15, 2004
COUNTY OF SANTA CRUZ
SUSAN A. MAURIELLO
EX-OFFICIO CLERK OF THE BOARD
BY Sharon Mitchell DEPUTY

BOARD OF SUPERVISORS
County of Santa Cruz
701 Ocean St., Fifth Floor
Santa Cruz, CA. 95060

SUBJECT: Approval of Mental Health Agreements

Dear Members of the Board:

The Health Services Agency (HSA) requests your Board's approval of six (6) Community Mental Health (CMH) agreements, which are for routine business.

State Department of Mental Health: HSA requests your Board's approval of the State standard revenue agreement for Mental Health Managed Care for 2004-05. This on-going agreement provides state funding for managed care services which CMH has been financially and programmatically responsible for since January 1995. Estimated revenue of $1,913,993 from this agreement has been included in HSA's recommended budget for 2004-05.

County Office of Education: HSA requests your Board's approval of a new revenue agreement with the County Office of Education in the amount of $587,622 which partially funds state mandated mental health services to special education pupils. This agreement is a result of partial legislative remedy of the State's financial obligation to fully fund these services. The remainder of the cost of delivering mental health care to these students, which is approximately $350,000, will be included on the appropriate SB90 state mandate claim at year end.

State Department of Mental Health: HSA requests your Board's approval of a new State standard agreement for the usage of and payment for beds at State operated mental hospitals. These services were previously contracted for within the SB900 Performance Contract, which outlines the County's responsibility for delivering mental health services to our residents under State law. The State removed the language related to state hospital beds from the Performance Contract and created a new agreement specific to these services. The $265,969 cost for these beds was included in the 2003-04 budget.

State Department of Rehabilitation: HSA requests your Board's approval of an amendment to the agreement with State Department of Rehabilitation (DOR). In FY 1992-93, your Board approved the first agreement between CMH and DOR which joined these two agencies with Volunteer Center to maximize local, state and federal resources to improve employment opportunities for persons with severe mental disabilities. The

attached amendment to the 2003-04 agreement increases the in-kind staff time match dedicated to the program and reduces the required cash payment to DOR. This will save $58,042 in Realignment funds that were previously used to provide the match for the program but will reduce Short-Doyle MediCal revenues by approximately $39,000 for a positive gain of $19,000.

ValueOptions: HSA requests your Board's approval of a new agreement effective July 1, 2004 with ValueOptions. Since 1998, CMH has contracted with its statewide association, the California Mental Health Directors Association (CMHDA), to provide mandated mental health services to adolescents placed in out-of-county foster care and group homes. CMHDA performed these duties through an administrative service provider, ValueOptions, who contracted with local provider panels to serve these youth. Since this program is now operational and stable, CMHDA re-assessed it role in the program and then notified the counties that it was discontinuing its participation in this program and that ValueOptions would contract directly with each county for these services. CMH budgets approximately $7,000 each year for these services, and has included that amount in the recommended budget for 2004-05.

JC Nationwide: HSA requests your Board's approval of a new agreement effective June 1, 2004 with JC Nationwide. This organization provides psychiatric locum tenens services which allow CMH to continue providing vital medical services during psychiatrist recruitment vacancy periods. CMH contracts with a variety of these vendors to insure that options are available to continue services when staff turnover occurs. This agreement provides temporary psychiatrists at a rate of $112 per hour.

The above agreements require no new county general funds to implement.

It is, therefore, RECOMMENDED that your Board:

1. Approve the attached agreements with the State Department of Mental Health, Contract R680, a 2004-05 revenue agreement for mental health managed care funding, Santa Cruz County Office of Education, a new revenue agreement for school mental health services funding, State Department of Mental Health, a new agreement in the amount of $265,969 for mental health state hospital beds, State Department of Rehabilitation, Contract 0603, an amendment decreasing the maximum amount by $58,042 to $57,955, ValueOptions, a new agreement for out-of county mental health care for adolescents at various rates as specified in the contract, and JC Nationwide, a new agreement at a rate of $112 per hour for locum tenens psychiatric services, and authorize the Health Services Agency Director to sign.

RECOMMENDED

Susan A. Mauriello
County Administrative Officer

Sincerely,

Rama Khalsa, Ph.D.
Health Services Agency Director

cc: County Administrative Office
County Counsel
Auditor-Controller

HSA Administration
Mental Health Administration

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COUNTY OF SANTA CRUZ
REQUEST FOR APPROVAL OF AGREEMENT

0379

TO. Board of Supervisors
County Administrative Office
Auditor Controller

FROM: **Health Services Agency** (Department)

BY: _____ (Signature) 5/19/04 (Date)
Signature certifies that appropriations/revenues are available

AGREEMENT TYPE (Check One) Expenditure Agreement ☐ Revenue Agreement ☒

The Board of Supervisors is hereby requested to approve the attached agreement and authorize the execution of same.

1. Said agreement is between the **Health Services Agency - Mental Health** (DepartmenUAgency)

and **State Dept of Mental Health, 1600 9th St, Sacramento, CA 95814** (NamelAddress)

2. The agreement will provide **funding for mental health managed care for FY 2004-05**

State Contract 04-74057-000

3. Period of the agreement is from **July 1, 2004** to **June 30,2005**

4. Anticipated Cost Is $ **NA - estimated revenue of $1,913,993** ☐ Fixed ☐ Monthly Rate ☐ Annual Rate ☐ Not to Exceed

Remarks: _____

5. Detail: ☐ On Continuing Agreements List for FY **04 - 05** Page CC-_____ Contract, No: **R680** OR ☐ 1st Time Agreement
☐ Section II — **No** Board letter required, will be listed under Item 8
☐ Section III — Board letter required
Section IV — Revenue Agreement

6. Appropriations/Revenues are available and are budgeted in **363101** (Index) **0618** (Sub object)

NOTE: IF APPROPRIATIONS ARE INSUFFICIENT, ATTACHED COMPLETED AUD-74 OR AUD-60

Appropriations ~~are~~ / are not available and ~~have been~~ / will be encumbered.

Contract No: R680

By: _____ Date: 6/4/04
Auditor-Controller Deputy

Proposal and accounting detail reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize

Health Services Agency Director (Dept/Agency Head) to execute on behalf of the _____

Health Services Agency (DepartmenVAgency)

Date: _____

By: _____
County Administrative Office

Distribution:
Board of Supervisors - White
Auditor Controller - Canary
Auditor-Controller - Pink
Department - Gold

ADM - 29 (8101)
Title I, Section 300 Proc Man

State of California
County of Santa Cruz
I, Susan A. Mauriello ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz, State of California, do hereby certify that the foregoing request for approval of agreement was a p proved by said Board of Supervisors as recommended by the County Administrative Office by an order duly entered in the minutes of said Board on June 15 20 04

By: Deputy Clerk

AUDITOR-CONTROLLER USE ONLY

CO_____ $_____ _____ _____
Document No. JE Amount Lines H/TL Keyed By Date

TCI 10_____ $_____ /_____
Auditor Description Amount Index Sub object User Code 27

A ARD AGREEMENT

D. 213 (NEW 02/98)

CONTRACTOR COPY

Agreement Number	Amendment Nbr.
04-74057-000	

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

State Agency's Name.

Department of Mental Health

RESOLUTION/MINUTE ORDER ATTACHED

Contractor's Name:

Santa Cruz County Mental Health & Substance Abuse Svcs

2. The Term of this Agreement is: **July 01,2004 Through June 30,2005**

3. The maximum amount of this agreement is: **$1,913,993.00**
One Million Nine Hundred Thirteen Thousand Nine Hundred Ninety Three Dollars And No Cen

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

Exhibit A - Scope of Work	Page(s)	46
Exhibit B - Budget Detail and Payment Provision	Page(s)	3
* Exhibit C - General Terms and Conditions	Form:	GTC 304 Dated 3/1/2004
Exhibit D - Special Terms and Conditions	Page(s)	5
Exhibit E - Additional Provision	Page(s)	80

*View at: http://www.ols.das.ca.aov/Standard+Lanquaae/default.htm'

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

CONTRACTOR

CONTRACTOR'S NAME *(Ifother than an individual, state whether a corporation, partnership, etc.)*

Santa Cruz County **Mental Health & Substance Abuse Svcs**

BY *(Authorized Signature)* — DATE SIGNED: 6-15-04

PRINTED NAME AND TITLE OF PERSON SIGNING

Rama Khalsa- Health Director

1400 Emeline Avenue

Santa Cruz, CA 95060

STATE OF CALIFORNIA

AGENCY NAME

Department **of Mental Health**

BY *Authorized Signature* — DATE SIGNED: 6/21/04

PRINTED NAME AND TITLE OF PERSON SIGNING

Acting Procurement and Contracting Officer

ADDRESS **1600 9th** Street

Sacramento, CA 95814

California
Department of General Services
Use Only

FULLY EXECUTED

APPROVED
JUN 2 5 2004
OEPT OF GENERAL SERVICES

0381

EXHIBIT A
SCOPE OF WORK
JULY 1, 2004 – JUNE 30, 2005

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

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

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

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

Department of Mental Health County Operations Doug Mudgett (916) 654-3623 Fax: (916) 654-5591	Santa Cruz County Mental Health and Substance Abuse Services Norm Wyman, MFT, Director Fax: (831) 454-4663; (831) 454-4519

Direct all inquiries to:

Department of Mental Health County Operations Section 1600 9th Street, Room 100 Sacramento. CA 95814	Santa Cruz County Mental Health and Substance Abuse Services Norm Wyman, MFT, Director 1400 Emeline Avenue Santa Cruz, CA 95060

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

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

SERVICE DELIVERY, ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS

0382

A. Provision of Services

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

The Contractor shall furnish all medically necessary covered services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under the regular Medi-Cal program, which includes Short-Doyle/Medi-Cal services. The Contractor shall ensure that all medically necessary covered services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered service solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

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

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

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

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

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

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

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

In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor shall not exclude a beneficiary solely on the grounds that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system

contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. For services provided pursuant to Section C, the Contractor shall consider the following **ICD-9** diagnoses codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use **DSM** IV. 0383

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

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

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

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

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

B. Availability and Accessibility of Service

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

1. the anticipated number of Medi-Cal clients
2. the expected utilization *of* services, taking into account the characteristics and mental health needs of the beneficiaries of the county
3. the expected number and types of providers in terms of training and experience needed to meet expected utilization
4. the number of contract providers not accepting new Medi-Cal clients
5. the geographic location of providers considering distance, travel time, means of transportation ordinarily used by Medi-Cal clients, and physical access for disabled clients.

0384

The Contractor shall require that contract providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the provider also serves enrollees of a commercial health plan, or that are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor or another Mental Health Plan, if the provider serves only Medi-Cal clients.

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

C. Ernergency Psychiatric Condition Reimbursement

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

Title 42, CFR, Section 438.114(a) provides the following definitions: *"Emergency medical condition* means a medical condition manifesting itself by acute symptoms *of* sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part. *Emergency services* means covered inpatient and outpatient services that are as follows: (1) Furnished by a provider that is qualified to furnish these services under this title. (2) Needed to evaluate or stabilize an emergency medical condition." The Contractor's responsibilities for emergency psychiatric conditions under this section operationalize these definitions in psychiatric terms. To the extent that there is a conflict between the definitions in Title 42, CFR, Section 438.1 14 and the Contractor's obligations as described in this section, the federal regulation shall prevail as provided in Exhibit E, Section 3.

Notwithstanding Title 9, CCR, Section 1820.225, the Contractor shall apply the prudent layperson standard in determining coverage of services to treat a beneficiary's emergency psychiatric condition. Application of the prudent layperson standard means that the Contractor shall not deny reimbursement for

emergency room services covered by the Contractor if a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention for a condition covered by the Contractor to result in a danger to self or others or an immediate inability to utilize food, shelter or clothing. In addition the Contractor shall not deny reimbursement for covered services when a representative of the Contractor instructs a beneficiary to seek emergency services.

Notwithstanding Title 9, CCR, Section 1820.225, effective with dates of services on or after August 13, 2003, the Contractor shall not deny treatment authorization requests (TARs) for psychiatric hospital inpatient services for a hospital's failure to notify the Contractor of an emergency admission as required by Title 9, CCR, Section 1810.225(d)(1), which provides that TARs shall be approved when a hospital notifies the Point of Authorization within 24 hours of admission of a beneficiary to the hospital or within the time required by contract. The Contractor may deny such TARs for failure of timely notification only if the notification is provided more than 10 calendar days from the presentation for emergency services.

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

D. Organizational and Administrative Capability

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

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

2. Beneficiary problem resolution processes.

3. Provider problem resolution and appeal processes.

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

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

TBS that are fully supported by an assessment and TBS client plan may be approved for 60 days or 120 hours, whichever is less.

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

1) The beneficiary's progress towards the specific goals and timeframes of the TBS client plan. **A** strategy to decrease the inte'nsity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness.

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

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

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

f. When the Contractor approves a fourth MHP payment authorization request for a beneficiary, the Contractor shall provide a summary of the TBS services provided, justification for the additional authorization and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, in writing to the Mental Health Director for the Contractor and to the Deputy Director, Systems *of* Care, Department of Mental Health, within five working days of the authorization decision.

Z. Program Integrity Requirements

The Contractor shall comply with Title 42, CFR, Section 438.608, in which the Contractor is a PIHP (Prepaid Inpatient Health Plan), which provides:

Sec. 438.608 Program integrity requirements.
(a) General requirement. The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

(b) Specific requirements. The arrangements or procedures must include the following: 0402

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

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.

(3) Effective training and education for the compliance officer and the organization's employees.

(4) Effective lines of communication between the compliance officer and the organization's employees.

(5) Enforcement of standards through well-publicized disciplinary guidelines.

(6) Provision for internal monitoring and auditing.

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

0403

RECONCILIATIONWITH FEDERAL REGULATIONS

The Department and the Contractor agree that where there is a conflict between Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter C, Part 438, and Title 9, California Code of Regulations (CCR), Division 1, Chapter 11, and a waiver of the CFR section has not be granted to the State, the Contractor shall comply with the federal regulations as provided in this attachment.

A. Notification of Beneficiaries

NotwithstandingTitle 9, CCR, Section 1810.360, the Contractor shall comply with the informing requirements of Title 42, CFR, Section 438.10 as provided in Exhibit A, Attachment 1, Section V.

B. MHP Pavment Authorization

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

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

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

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

   c. Consult with the'requesting provider when appropriate.

2. NotwithstandingTitle 9, CCR, Sections 1820.220 and 1830.215, the Contractor shall act on MHP authorization requests in accordance with the following timeframes:

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

beneficiary with written notice of the decision on the date the decision to extend is made. The notice to the beneficiary shall advise the beneficiary of the reason for the decision and the beneficiary's right to file a grievance if the beneficiary disagrees with the decision. 0404

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

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

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

C. Beneficiary Problem Resolution Processes

1. The Contractor shall maintain beneficiary problem resolution processes in accordance with Title 42, CFR, Chapter IV, Subchapter C, Part 438, Subpart F, "Grievance Systems," and the Medi-Cat Specialty Mental Health Services Consolidation waiver renewal request as approved by the Centers for Medicare and Medicaid Services on April 24, 2003 and August 22, 2003, that enable beneficiaries to resolve concerns or complaints about any specialty mental health service-related issue. Notwithstanding Title 9, Section 1850.205, the Contractor's beneficiary problem resolution processes shall include a grievance process, an appeal process, and an expedited appeal process as described in this Section.

For the purposes of this contract Section, the following definitions apply:

a. Grievance: An expression of dissatisfaction about any matter other than a matter covered by an Appeal as defined in b. below.

b. Appeal: A request for review of an action as defined in subsection c. below or for review of a provider's determination to deny, in whole or in part, a beneficiary's request for a covered specialty mental health service or for review of a determination by the Contractor or its providers that the medical

necessity criteria in Title 9, CCR, Section 1830.205(b)(1), (b)(2), and (b)(3)(C) have not been met and the beneficiary is not entitled to any specialty mental health services from the Contractor.

c. Action: An action occurs when the Contractor does at least one of the following:

(1) Denies or modifies MHP payment authorization of a requested service, including the type or level of service;

(2) Reduces, suspends, or terminates a previously authorized service;

(3) Denies, in whole or in part, payment for a service prior to the delivery of the service or denies, in whole or in part, payment for a service post-service delivery but pre-payment based on a determination that the service was not medically necessary or otherwise not a service covered by this contract;

(4) Fails to provide services in a timely manner, as determined by the Contractor or;

(5) Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

2. For both the grievance and the appeal processes, the Contractor shall:

a. Ensure that each beneficiary has adequate information about the Contractor's processes by, at a minimum:

(1) Including information describing the grievance and the appeal process in the Contractor's beneficiary brochure.

(2) Posting notices explaining grievance and appeal process procedures in locations at all Contractor provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. For the purposes of this Contract, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain specialty mental health services.

(3) Making grievance and appeal forms and self addressed envelopes available for beneficiaries to pick up at all Contractor provider sites without having to make a verbal or written request to anyone.

(4) Making interpreter services and toll-free numbers with adequate TDD/TTY and interpreter services available to beneficiaries at a minimum during normal business hours.

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b. Allow a beneficiary to authorize another person to act on his/her behalf. The beneficiary may select a provider as his or her representative in the appeal process.

C. Allow a beneficiary's legal representative to use the grievance or the appeal processes on the beneficiary's behalf.

d. Identify a staff person or other individual as having responsibility for assisting a beneficiary with the problem resolution processes at the beneficiary's request.

e. Not subject a beneficiary to discrimination or any other penalty for filing a grievance or appeal.

f. Have procedures for the processes that maintain the confidentiality of beneficiaries.

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

h. Record the final dispositions of grievances and appeals, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

ı. Provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance or appeal.

J. Acknowledge the receipt of each grievance or appeal to the beneficiary in writing.

k. Have procedures by which issues identified as a result of the grievance or appeal processes are transmitted to the Contractor's .Quality Improvement Committee, .the Contractor's administration or another appropriate body within the Contractor's organization for review and, if applicable, implementation of needed system changes.

l. Notify,those providers cited by the beneficiary or otherwise involved in the grievance or appeal of the final disposition of the beneficiary's grievance or appeal.

m. Ensure that the Contractor's logs and any other grievance and appeal process files, be open for review by the Department, the State Department of Health Services, and any appropriate oversight agency.

n. Notify contract providers *of* the following at the time they enter into a contract:

(1) The beneficiary's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;

(2) The beneficiary's right to file grievances and appeals and their requirements and timeframes for filing;

(3) The availability of assistance in filing;

(4) The toll-free numbers to file oral grievances and appeals;

(5) The beneficiary's right to request continuation of benefits during an appeal or State fair hearing filing; and

(6) The Contractor's provider problem resolution process pursuant to Title 9, CCR, Section 1850.305

o. Allow for providers, other than the Contractor, to establish grievance and appeal processes for beneficiaries receiving services from them. When such processes exist, the Contractor shall not require .beneficiaries to use or exhaust the provider's processes prior to using the Contractor's beneficiary problem resolution process, unless:

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

(2) The provider's beneficiary problem resolution process fully complies with Title 42, CFR, Chapter IV, Subchapter C, Part 438, Subpart F and this Section; and

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

p. Ensure that no provision of the Contractor's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

q. Not permit a beneficiary to file a grievance or appeal directly with the State.

3. In addition to meeting the Contract requirements listed in Section C.2 above, the grievance process shall, at a minimum:

a. Provide for resolution of a beneficiary's grievance as quickly and simply as possible.

b. Involve simple, and easily understood procedures that allow beneficiaries to present their grievance orally or in writing.

c. Ensure that the individuals making the decision on the grievance were not involved in any previous level of review or decision-making; and, if the grievance is regarding the denial of an expedited resolution of an appeal, or is about clinical issues, ensure that the decision-maker has the appropriate clinical expertise, as determined by the Contractor and scope of practice considerations, in treating the beneficiary's condition.

d. Identify the roles and responsibilities of the Contractor, the provider, and the beneficiary.

e. Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest.

f. If the Contractor fails to notify the affected parties of the grievance decision within the timeframes in subsection e., provide a notice of action to the beneficiary advising the beneficiary of the right to request a fair hearing. The Contractor shall provide the notice of action on the date that the timeframe expires.

g. Notify the beneficiary or the beneficiary's representative in writing of the grievance decision or document the notification or efforts to notify the beneficiary, if he or she could not be contacted.

4. In addition to meeting the requirements listed in the Section C.2 above, the Contractor shall establish and maintain an appeal process that shall, at a minimum:

a. Allow a beneficiary to file an appeal orally, or in writing. Standard oral appeals shall be followed-up with written, signed appeals. The Contractor shall treat the oral appeal as an appeal to establish the earliest possible filing date.

b. Ensure that the individuals making the decision on the appeal were not involved in any previous level of review or decision-making; and, if the appeal is regarding a denial based on lack of medical necessity, or is about clinical issues, ensure that the decision-maker has the appropriate clinical expertise, as determined by the Contractor and scope of practice considerations, in treating the beneficiary's condition.

c. Inform the beneficiary of his or her right to request a fair hearing at any time before, during or after the appeal process has begun.

d. Allow the beneficiary to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.

e. Allow the beneficiary andlor his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered during the appeal process before and during the appeal process.

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

g. Provide for a decision on the appeal and notify the affected parties within **45** calendar days of receipt of the appeal. This timeframe may be extended by up to **14** calendar days if the beneficiary requests an extension, or the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest.

h. If the Contractor fails to notify the affected parties of the appeal decision within the timeframes in subsection g., provide a notice of action to the beneficiary advising the beneficiary of the right to request a fair hearing. The Contractor shall provide the notice of action on the date that the timeframe expires.

i. Notify the beneficiary and/or his/her representative of the resolution of the appeal in writing. The notice shall contain:

(1) The results of the appeal resolution process, and;

(2) The date that the appeal decision was made;

(3) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a state fair hearing and the procedure for filing for a state fair hearing.

j. Promptly provide or arrange and pay for the disputed services if the decision *of* the appeal resolution process reverses a decision to deny services.

k. Identify the roles and responsibilities of the Contractor, the provider, and the beneficiary.

5. The Contractor shall develop and maintain a system for an Expedited Review Process for Appeals in accordance with Title 42, CFR, Section **438.408** (b)(3). An expedited review process for appeals shall take place when the Contractor determines or the beneficiary and/or the provider certifies that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. For expedited appeals, in addition to meeting the contract provisions listed in Section C.2 and Section C.4(b) through (9 and (i) and (j) above, the Contractor shall:

a. Allow the beneficiary to file the request orally without written follow-up. 0410

b. Ensure that punitive action is not taken against a beneficiary or a provider who requests an expedited resolution or supports a beneficiary's appeal.

c. Resolve an appeal and notify the affected parties in writing, no later than three working days after the Contractor receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the Contractor determines that there is need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the enrollee, give the beneficiary written notice of the reason for the delay.

d. If the Contractor fails to notify the affected parties of the appeal decision within the timeframes in subsection c., provide a notice of action to the beneficiary advising the beneficiary of the right to request a fair hearing. The Contractor shall provide the notice of action on the date that the timeframe expires.

e. Provide beneficiary with written notice of the expedited appeal disposition and also make reasonable efforts to provide oral notice to the beneficiary and/or his/her representative. The written notice shall meet the requirements specified in (h) of the Section C.4 above.

f. If the Contractor denies a request for expedited resolution of an appeal, the Contractor shall:

(1) Transfer the appeal to the timeframe for standard appeal resolution; and

(2) Make reasonable efforts to give the beneficiary and hislher representative prompt oral notice of the denial of the expedited appeal process, and follow up within two calendar days with a written notice.

D. Fair Hearing and Notice of Action

In accordance with Title 42, CFR, Chapter IV, Subchapter C, Part 438, Subpart F, "Grievance Systems," and the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request as approved by the Centers for Medicare and Medicaid Services on April 24, 2003 and August 22, 2003, the Contractor shall comply with Title 9, CCR, Section 1850.210, except that:

1. Notwithstanding subsection (a)(1) of Title 9, CCR, Section 1850.210, when the Contractor denies MHP payment authorization of a service that has already been delivered to the beneficiary as a result of a post-service, pre-payment determination by the Contractor that the service was not medically necessary or otherwise not a service covered by this contract, the Contractor shall provide the beneficiary notice of action in accordance with the remaining provisions of the Title 9, CCR, Section 1850.210.

2. Notwithstanding subsection (b) of Title 9, CCR, Section 1850.210, when the Contractor does not have sufficient information *to* approve or deny an MHP payment authorization request from a provider within the time frames required by Section B.2.a., "MHP Payment Authorization", the Contractor shall deny the MHP payment authorization request and provide the beneficiary notice of action in accordance with the remaining provisions of the Title 9, CCR, Section 1850.210. *041 1*

3. Notwithstanding subsection (b) of Title 9, CCR, Section 1850.210, when the Contractor does not have sufficient information to approve or deny an MHP payment authorization request from a provider within the time frames required by Section B.2.b., "MHP Payment Authorization", the Contractor shall deny the MHP payment authorization request and provide the beneficiary notice of action in accordance with the remaining provisions of the Title 9, CCR, Section 1850.210.

4. Notwithstanding subsection (d) of Title 9, CCR, Section 1850.210, the Contractor shall include information regarding the beneficiary's right to request an expedited fair hearing in accordance with Title 42, CFR, Section 431.244(f)(3) on the notice of action.

5. Notwithstanding Title 9, CCR, Section 1850.210, the Contractor shall provide notices of action as required in Section C.3.f, C.4.h., and C.5.d.

E. Post-Stabilization Care Services

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

   a. Are prior authorized by the Contractor

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

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

      (1) The Contractor does not respond to an MHP payment authorization request for prior authorization within one hour;

      (2) The Contractor cannot be contacted; or

      (3) The Contractor and the treating physician cannot reach an agreement concerning the beneficiary's care and a Contractor-designated physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor-designated physician and the treating physician may continue with care of

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the beneficiary until a Contractor-designated physician is reached or one of the criteria in paragraph 2. is met.

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

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

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

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

   d. The beneficiary is discharged.

F. Emergency Psychiatric Condition Reimbursement

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

ADDITIONAL REQUIREMENTS BASED ON FEDERAL REGULATIONS 0413

1. The Contractor shall maintain written policies and procedures respecting advance directives in compliance with the requirements of Title 42, Code of Federal Regulations (CFR), Sections 422.128 and 438.6(i)(1), (3) and (4). Any written materials prepared by the Contractor for beneficiaries shall be updated to reflect changes in state laws governing advance directives as soon as possible, but no later than 90 days after the effective date of the change.

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

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

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

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

6. The Contractor shall obtain prior approval from the Department if the Contractor intends to refuse to provide or arrange and pay for a covered service because the Contractor objects to the service on moral or religious grounds. The Department shall approve the request only if the State is able to provide adequate access to the service or services the Contractor does not intend to provide. If the Department does not approve the request, the Contractor may terminate the contract in accordance with Exhibit E, Section 4.8.

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

cost and co-payments. The Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which the State does not pay the Contractor, for costs of covered services for which the State or the Contractor does not pay the Contractor's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition. 0414

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

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

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

10. Consistent with the requirements of Exhibit A, Attachment 1, Section J, and Title 42, CFR, Section 438.10, the Contractor shall:

    A. Ensure that written materials developed by the Contractor for beneficiaries use easily understood language and format.

B. Make written materials available to beneficiaries in alternate formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. 0415

C. Make oral interpretation services available free of charge to beneficiaries in all non-English languages.

11. The Contractor shall certify each claim submitted to the State in accordance with Title 9, CCR, Section 1840.112 at the time the claims are submitted to the State. The Contractor's Chief Financial Officer or equivalent or an individual with authority delegated by the Chief Financial Officer shall sign the certification under penalty of perjury that the state share of payment for services covered by the claim has been provided in order to satisfy the matching requirements for federal financial participation. The Contractor's Mental Health Director or an individual with authority delegated by the Mental Health Director shall sign the certification under penalty of perjury that, to the best of his or her knowledge and belief, the claim is in all respects true, correct and in accordance with the law and meets the requirements of Title 9, CCR, Section 1840.112(b). The Contractor shall have mechanisms that support the Mental Health Director's certification, including the certification that the services for which claims were submitted were actually provided to the beneficiary. If the Department requires additional information from the Contractor that will be used to establish State payments to the Contractor, the Contractor shall certify the additional information provided in accordance with Title 42, CFR, Section 438.604..

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

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

Quality Improvement Program 0416

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

- The QI Program Description shall be evaluated annually and updated as necessary
- The QI Program shall be accountable to the MHP Director.
- A licensed mental health staff person shall have substantial involvement in QI Program implementation.
- The MHP's practitioners, providers, consumers and family members shall actively participate in the planning, design and execution of the QI Program.
- The role, structure, function and frequency of meetings of the QI Committee and other relevant committees shall be specified.
  - The QI Committee shall oversee and be involved in QI activities, including performance improvement projects
  - The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; and ensure follow-up of QI processes
  - Dated and signed minutes shall reflect all QI Committee decisions and actions
- The QI Program shall coordinate with performance monitoring activities throughout the MHP, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances and fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, and clinical records review
- Contracts with hospitals and with individual, group and organizational providers shall require:
  - cooperation with the MHP's QI Program, and
  - access to relevant clinical records to the extent permitted by State and Federal laws by the MHP and other relevant parties.

B. The QI Program shall have an Annual QI Work Plan including the following:

- An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects:
- Monitoring of previously identified issues, including tracking of issues over time;
- Planning and initiation of activities for sustaining improvement, and
- Objectives, scope, and planned activities for the coming year, including QI activities in each of the following six areas. The QI activities in at least *two* of the six areas and any additional areas required by the Centers for Medicare and Medicaid Services in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a)(2) shall meet the criteria identified in Title 42, CFR, Section 438.240(d) for performance improvement projects. At least one performance improvement project shall focus in a clinical area and one in a nonclinical area.

0417

1. Monitoring the service delivery capacity of the MHP:

- The MHP shall implement mechanisms to assure the capacity of service delivery within the MHP
  - The MHP will describe the current number, types and geographic distribution of mental health services within its delivery system.
  - The MHP shall set goals for the number, type, and geographic distribution of mental health services

2. Monitoring the accessibility of services:

- In addition to meeting Statewide standards, the MHP will set goals for:
  a. Timelines of routine mental health appointments;
  b. Timeliness of services for urgent conditions;
  c. Access to after-hours care; and
  d. Responsiveness of the MHP's 24 hour, toll free telephone number.
- The MHP shall establish mechanisms to monitor the accessibility of mental health services, services for urgent conditions and the 24 hour, toll free telephone number

3. Monitoring beneficiary satisfaction

- The MHP shall implement mechanisms to ensure beneficiary or family satisfaction.
- The MHP shall assess beneficiary or family satisfaction by:
  - surveying beneficiary/family satisfaction with the MHP's services at least annually
  - evaluating beneficiary grievances and fair hearings at least annually; and
  - evaluating requests to change persons providing services at least annually
- The MHP shall inform providers of the results of beneficiary/family satisfaction activities

4. Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices.

- The scope and content of the QI Program shall reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries.
  Annually the MHP shall identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.
  - These clinical issues shall include a review of the safety and effectiveness of medication practices. The review shall be under the supervision of a person licensed to prescribe or dispense prescription drugs
  - In addition to medication practices, other clinical issue(s) shall be identified by the MHP.
- The MHP shall implement appropriate interventions when individual occurrences of potential poor quality are identified
- At a minimum the MHP shall adopt or establish quantitative measures to assess performance and to identify and prioritize area(s) for improvement

- Providers, consumers and family members shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice andlor administrative aspects of the delivery system 0418

5. Monitoring continuity and coordination of care with physical health care providers and other human services agencies
- The MHP shall work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries
    - When appropriate, the MHP shall exchange information in an effective and timely manner with other agencies used by its beneficiaries
    - The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans

6. Monitoring provider appeals

- The following process shall be followed for each of the QI work plan activities #1 - 6 identified above that are not conducted as performance improvement projects, to ensure the MHP monitoring the implementation of the QI Program. The MHP shall follow the steps below for each of the QI activities:
    1. collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified
    2. identify opportunities for improvement and decide which opportunities to pursue
    3. design and implement interventions to improve its performance
    4. measure the effectiveness of the interventions
    5. incorporate successful interventions in the MHP as appropriate.

C. If the MHP delegates any QI activities there shall be evidence of oversight of the delegated activity by the MHP
- A written mutually agreed upon document shall describe:
    - the responsibilities of the MHP and the delegated entity
    - the delegated activities
    - the frequency of reporting to the MHP
    - the process by which the MHP shall evaluate the delegated entity's performance, and
    - the remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations

- Documentation shall verify that the MHP:
    - evaluated the delegated entity's capacity to perform the delegated activities prior to delegation
    - approves the delegated entity's QI Program annually or as defined by contract terms
    - evaluates annually whether the delegated activities are being conducted in accordance with State and MHP Standards; and
    - has prioritized and addressed with the delegated entity those opportunities identified for improvement

Utilization Management Program

041 9

1. The MHP shall have a written description of the Utilization Management (UM) program, in which structures and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements shall be included in the written UM program description:
   a) Licensed mental health staff shall have substantial involvement in UM program implementation.
   b) A description of the authorization processes used by the MHP:
      i) Authorization decisions shall be made by licensed or "waiveredhegistered" mental health staff consistent with State regulations.
      ii) Relevant clinical information shall be obtained and used for authorization decisions. There shall be a written description of the information that is collected to support authorization decision-making.
      iii) The MHP shall use the statewide medical necessity criteria to make authorization decisions.
      iv) The MHP shall clearly document and communicate the reasons for each denial.
      v) The MHP shall send written notification to its beneficiaries and providers of the reason for each denial.
   c) The MHP shall provide the statewide medical necessity criteria to its providers, consumers, family members and others upon request.
   d) Authorization decisions shall be made in accordance with the statewide timeliness standards for authorization of services for urgent conditions established in state regulation.
   e) The MHP shall monitor the UM program to ensure it meets the established standards for authorization decision making, and take action to improve performance if it does not meet the established standards.
   f) The MHP shall include information about the beneficiary grievance and fair hearing processes in all denial or modification notifications sent to the beneficiary.

2. The MHP shall evaluate the UM program as follows:
   a) The UM program shall be reviewed annually by the MHP, including a review of the consistency of the authorization process.
   b) If an authorization unit is used to authorize services, at least every two years, the MHP shall gather information from beneficiaries and providers regarding their satisfaction with the UM program, and address identified sources of dissatisfaction.

3. If the MHP delegates any UM activities, there shall be evidence of oversight of the delegated activity by the MHP.
   a) **A** written mutually agreed upon document shall describe:
      i) The responsibilities of the MHP and the delegated entity
      ii) The delegated activities
      iii) The frequency of reporting to the MHP
      iv) The process by which the MHP evaluates the delegated entity's performance, and
      v) The remedies, including revocation of the delegation, available to the MHP **if** the delegated entity does not fulfill its obligations.

b) Documentation shall verify that the MHP:

i) Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation

ii) Approves the delegated entity's UM program annually

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

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

Documentation Standards For Client Records 0421

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

A. Assessments

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

- Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
- Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
- Documentation shall describe client strengths in achieving client plan goals.
- Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
- Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
- A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
- Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the counter drugs.
- A relevant mental status examination shall be documented.
- A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and /or other assessment data.

2. Timeliness/Frequency Standard for Assessment

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

B. Client Plans

1. Client Plans shall:

- have specific observable and/or specific quantifiable goals

E. Quality Management 0386

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

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

If the Contractor notified the Department of its intent to extend the study pursuant to Exhibit A, Attachment 1, Section **E** of its Fiscal Year 2003-04 contract with the Department, the Contractor shall provide the Department with information on the design, progress and outcome of the study of Latino access if required by Exhibit A, Attachment 1, Section E, of the Contractor's Fiscal Year 2002-03 contract with the Department, upon request. The Contractor shall complete the study by June 30,2005.

F. Beneficiary Records

The Contractor shall maintain at a site designated by the Contractor for each beneficiary who has received services a legible record kept in detail consistent with Appendix C (consisting of three pages), which is incorporated herein by reference, and good professional practice which permits effective quality management processes and external operational audit processes, and which facilitates an adequate system for follow-up treatment. References to the client in Appendix C are references to beneficiaries who have received services through the Contractor. If a beneficiary receives only psychiatric inpatient hospital services, the Contractor need not maintain a record for the beneficiary in addition to the record maintained by the facility, provided the Contractor and appropriate oversight entities have access to the facility's record as provided in Exhibit E, Section 7, Item D.g.

G. Review Assistance

The Contractor shall provide any necessary assistance to the Department in its conduct of facility inspections, and operational reviews of the quality of care being provided to beneficiaries, including providing the Department with any requested documentation or reports in advance of a scheduled on site review.

The Contractor shall also provide any necessary assistance to the Department and the External Quality Review Organization contracting with the Department in the annual external quality review of the quality of care, quality outcomes, timeliness of, and access to, the services being provided to beneficiaries under this contract. Contractor shall correct deficiencies as identified by such inspections and reviews according to the time frames delineated in the resulting reports.

H. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan for Consolidation of Medi-Cal Specialty Mental Health Services pursuant Title 9, CCR, Section 1810.310 as approved by the Department, including the administration of beneficiary problem resolution processes as required by Exhibit A, Attachment 2, Section *C*. The Contractor shall obtain written approval from the Department prior to making any changes to the Implementation Plan as approved by the Department, except that changes in the Implementation Plan as a result of the implementation of the federal Medicaid managed care regulations that were effective August 13, 2002 shall not constitute a change in the Implementation Plan during the term of the contract. The Contractor may implement the changes after 30 calendar days if no notice is received from the Department, **as** provided in Title 9, CCR, Section 1810.310.

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

The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with Title 9, CCR, Section 1810.370. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU.

J. Cultural Competence Plan

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

K. Provider Selection and Certification

1. Provider Selection and Certification — General

The Contractor shall comply with Title 9, CCR, Section 1810.435 in the selection of providers and shall review its providers for continued compliance

with standards at least once every three years, except as otherwise provided in this contract. In addition, the Contractor shall: 0388

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

b. 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.

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

2. Certification of Organizational Providers

The Contractor shall certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Appendix **D** (consisting of three pages), which is herein incorporated by reference, prior to the date on which the provider begins to deliver services under the contract, and once every three years after that date, except as provided in Appendix D. The on site review required by Title 9, CCR, Section 1810.435(d) as a part of the certification process, shall be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

The Contractor may allow an organizational provider to begin delivering covered services to beneficiaries at a site subject to on site review prior to the date of the on site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on site review is the latest of the date the provider requested certification in accordance with the Contractor's certification procedures, the date the site was operational or the date a required fire clearance was obtained. The Contractor shall complete any required on-site review of a provider's sites within six months of the date 'the provider begins delivering covered services to beneficiaries at the site.

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

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the sites operated by an organizational provider to facilitate the claiming of

federal financial participation by the Contractor and the Department's tracking of that information.

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L. Recovery from Other Sources or Providers

The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance. The moneys recovered are retained by the Contractor; however, contractor claims for federal financial participation for services provided to beneficiaries under this contract shall be reduced by the amount recovered. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming federal financial participation for services provided to beneficiaries with other coverage under this contract as described in DMH Letter No. 95-01, dated January 31, 1995, or subsequent DMH Letters on this subject.

M. Third-Party Tort and Casualty Liability Insurance

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

1. If the State Department Health Services requests payment information and/or copies of paid invoices/claims for covered services to a beneficiary, the Contractor shall deliver the requested information within 30 days of the request. The value of the covered services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out of plan providers for similar services.

2. Information to be delivered shall contain the following data items:

   a. Beneficiary name.

   b. Full 14 digit Medi-Cal number.

   c. Social Security Number.

d. Date of birth.

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e. Contractor name.

f. Provider name (if different from the Contractor)

g. Dates of service.

h. Diagnosis code and/or description of illness.

I. Procedure code andlor description of services rendered.

j. Amount billed by a subcontractor or out of plan provider to the Contractor (if applicable).

k. Amount paid by other health insurance to the Contractor or subcontractor.

l. Amount and date paid by the Contractor to subcontractor or out of plan provider (if applicable).

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

3. The Contractor shall identify'to the State Department of Health Services the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

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

5. Information reported to the State Department of Health Services pursuant to this Section shall be sent to: State Department of Health Services, Third Party Liability Branch, 591 North 7th Street, Sacramento, California 95814

N. Financial Resources

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

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

O. Financial Report 0391

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

P. Books and Records

The Contractor shall maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records shall disclose the quantity of covered services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the beneficiaries eligible to receive covered services, the manner in which the Contractor administered its daily business, and the cost thereof.

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

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

Q. Transfer of Care

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

R. Department Policy Letters

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The Contractor shall comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9, CCR, Section 1810.226. Policy letters shall provide specific details of procedures established by the Department for performance of contract terms when procedures not covered in this agreement are determined to be necessary for performance under this agreement, but are not intended to change the basis and general terms of the contract.

S. Delegation

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

T. Fair Hearings

The Contractor shall represent the Contractor's position in fair hearings (as defined in Title 9, CCR, Section 1810.216.1) dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this contract. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

U. Crosswalk between Provider Coding System

The Contractor shall comply with Title 9, CCR, Section 1840.304 when submitting claims for federal financial participation for services billed by individual or group providers using service codes from the Health Care Financing Administration's Common Procedure Coding System (HCPCS). **At** such time as the table currently included in Section 1840.304 is deleted from this section, the Contractor shall follow the table issued by the Department as a DMH Information Notice.

V. Beneficiary Brochure and Provider Lists

1. The Contractor shall provide beneficiaries with the beneficiary brochure developed pursuant to Exhibit E, Section **6.F** upon request and when a beneficiary first receives a specialty mental health service from the Contractor

or its subcontracting providers, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Title 9, CCR, Section 1830.205 are met. 0393

The Contractor shall provide beneficiaries with the list of the Contractor's providers developed pursuant to Exhibit E, Section 6.F. upon request and when a beneficiary first receives a specialty mental health service from the Contractor or its subcontracting providers, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Title 9, CCR, Section 1830.205 are met.

2. The Contractor shall provide the Department or a contractor identified by the Department with county-specific information needed to update informing materials pursuant to Exhibit E, Section 6.F. on a timeline established by the Department.

3. Within 90 days of the date on which the Contractor receives informing materials prepared by the Department pursuant to Exhibit E, Section 6.F., the beneficiary brochure and provider list provided to beneficiaries by the Contractor under paragraph 1 of this section shall be the brochure and provider list provided by the Department to the Contractor pursuant *to* Exhibit E, Section 6.F.

W.' Compliance with the Requirements of Emilv Q v. Bonta

The Contractor shall comply with the provisions of the Final Judgment and Preliminary Injunction issued May 11, 2001, in the case of Emilv Q. v. Bonta, Case **No.** CV 98-4181 AHM (AIJx), United States District Court, Central District of California, that apply to the Contractor as determined by the Department.

X. Requirements for Dav Treatment Intensive and Day Rehabilitation

1. Authorization and Service Requirements

The Contractor shall require providers to request an initial mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.2.29, from the Contractor for day treatment intensive and for day rehabilitation. Provider as used in this section includes Contractor staff. The Contractor shall require providers to request MHP payment authorization from the Contractor in advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week. The Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive at least every three months and day rehabilitation at least every six months. The Contractor's MHP payment authorization function shall meet the criteria of Exhibit A, Attachment 2, Section B, except that the Contractor shall not delegate the MHP payment authorization function to providers. In the event that the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization

function does not include Contractor staff involved in providing day treatment intensive or day rehabilitation.

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

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

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

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

feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. 0395

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

1) Day rehabilitation shall include:

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

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

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

2). Day treatment intensive shall include:

a) Skill building groups and adjunctive therapies as described in subsection 1)b) and c) above. Day treatment intensive may also include process groups as described in subsection 1)a) above.

b) Psychotherapy, which means the use of psychosocial methods within a professional relationship to assist the client or clients to

achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups; or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention. 0396

c. **An** established protocol for responding to clients experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff shall have the capacity to handle the crisis until the client is linked to the outside crisis services.

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

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

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

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

The Contractor shall require that if day treatment intensive or day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a' clear audit trail is documented by the provider. The Contractor shall require that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive *of* other activities.

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

g. Documentation of day treatment intensive and day rehabilitation that meets the documentation standards described in Exhibit A-Attachment 1-Appendix C. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person'directing the service.

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

i. A written program description for day treatment intensive and day rehabilitation. Each provider of these services, including Contractor staff, shall be required to develop and maintain this program description. The written program description shall describe the specific activities of the service and reflect each of the required components of the services described in this section. The Contractor shall review the written program description for compliance with this section for individual and group providers that begin delivering day treatment intensive or day rehabilitation prior to the date the. provider begins delivering day treatment intensive or day rehabilitation.

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

3. Authorization Requirements for Related Services

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

Y. MHP Payment Authorization Requirements for Therapeutic Behavioral Service

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

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

When the Contractor's MHP payment authorization decisions result in denial, modification, deferral, reduction or termination of the services requested by the provider, the Contractor shall provide notices of action (NOAs) in accordance with the requirements of Title 9, CCR, Section 1850.210 and Exhibit **A** Attachment 2, Section D and, when required by Title 9, CCR, Section 1850.215, the continuation of services pending a fair hearing decision. When applicable, the NOA shall advise the beneficiary of the right to request continuation of previously authorized services pending the outcome of a Medi-Cal fair hearing if the request for hearing is timely.

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

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1. General Authorization Requirements

   a. The Contractor shall require providers to request MHP payment authorization for TBS in advance of the delivery of the services included in the authorization request.

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

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

   d. The Contractor shall issue a decision on an MHP payment'authorization request for TBS in accordance with the timeliness required by Exhibit A, Attachment 2, Section B and by Title 9, CCR, Section 1810.405 (c).

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

2. Initial Authorization

   The Contractor shall not approve an initial MHP payment authorization request that exceeds 30 days or 60 hours, whichever is less, except as specified in subsection 3.c. below. The initial authorization shall cover the provider conducting an initial TBS assessment, which shall identify at least one symptom or behavior TBS will address; developing an initial TBS client plan, which shall identify at least one TBS intervention; and providing the initial delivery of direct one-to-one TBS.

3. ,Reauthorization

   a. The Contractor shall not approve an MHP payment authorization request for reauthorization of TBS that exceeds 60 days or 120 hours, whichever is less.

   b. If the Contractor approved a provider's initial MHP payment authorization request under the provisions of subsection 2. above, the Contractor shall not approve the provider's first request for reauthorization unless the provider's request includes a TBS client plan that meets the following criteria:

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

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

3) A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.

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

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

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

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

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

c. When the provider's initial request for MHP payment authorization includes a completed TBS assessment and TBS client plan that meets the requirements of subsection b.1) through 7), the Contractor may authorize TBS services consistent with the limits of this section, i.e., an initial MHP payment authorization request that covers direct one-to-one

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- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by:
  - the person providing the service(s), or
  - a person representing a team or program providing services, or
  - a person representing the MHP providing services
  - when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
    - a physician
    - a licensed/"waivered" psychologist
    - a licensed/registered/waivered social worker
    - a licensed/registered/waivered marriage and family therapist or
    - a registered nurse

- In addition,
  - client plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
    - client signature on the plan shall be used as the means by which the MHP documents the participation of the client
      - when the client is a long term client as defined by the MHP, and
      - the client is receiving more than one type of service from the MHP
    - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.
    - the MHP shall give a copy of the client plan to the client on request.

2. Timeliness/Frequency of Client Plan:

- Shall be updated at least annually.
- The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1.

C. Progress Notes

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

- The client record shall provide timely documentation of relevant aspects of client care
- Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

- All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries shall include the date services were provided
- The record shall be legible
- The client record shall document referrals to community resources and other agencies, when appropriate
- The client record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment intensive

c. Weekly

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

d. Other

- Psychiatric health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services.

Provider Certification by the Contractor or the Department 0424

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

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

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

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

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

5. The organizational provider has a current administrative manual which includes: personnel policies and procedures; general operating procedures, service delivery policies, and procedures for reporting unusual occurrences relating to health and safety issues.

6. The organizational provider maintains client records in a manner that meets the requirements of the Contractor pursuant to Exhibit A, Attachment I, Section F, and applicable state and federal standards.

7. The organizational provider has staffing adequate to allow the Contractor to claim federal financial participation for the services the organizational provider delivers to beneficiaries, as described in Division 1, Chapter 11, Subchapter 4 of Title 9, CCR, when applicable.

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

9. The organizational provider has as head of service a licensed mental health professional or other appropriate individual as described in Title 9, CCR, Sections 622 through 630.

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

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

    B. Drugs intended for external use only or food stuffs are stored separately from drugs for internal use.

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

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

E. Drugs are not retained after the expiration date. IM multi-dose vials are dated and initialed when opened.

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

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

11. For organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with Exhibit A, Attachment 1, Section X, paragraph 1.

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

On-site review is not required for primary care and psychological clinics licensed under Division 2, Chapter 1 of the Health and Safety Code. Services provided by the clinics may be provided either on the premises or off site in accordance with the conditions of their license.

When an on site review of an organizational provider would not otherwise be required and the provider provides day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Exhibit A, Attachment 1, Section X, paragraph 1.

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

a) The provider makes major staffing changes.

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

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

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

e) There is a change of ownership or location.

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f) There are complaints regarding the provider.

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

EXHIBIT B
PAYMENT PROVISIONS

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1. The Department agrees to compensate the Contractor in accordance with the allocation amounts specified in Item **4** below under the conditions described in this Exhibit.

2. Budget Contingency Clauses

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

B. State Budget:

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

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

3. Prompt Payment Clause

Payment shall be made in accordance with, and within the time specified in Government Code, Chapter 45, commencing with Section 927.

4. Amounts Payable

The total amount payable for the 2004-05 Fiscal Year ending June **30,** 2005 is $1,913,993. The amount payable is an interim amount only and is subject to the development of the allocation amount for the. 2004-2005 Fiscal Year pursuant to Item 7. Any requirement of performance by the Department and the Contractor for this period shall be dependent upon the availability of future appropriations by the Legislature

for the purpose of this contract. The services shall be provided at the times required by this contract. 0428

5. Payment to the Contractor

The Contractor shall receive a single payment for the full amount payable under Item **4** for the fiscal year within 60 calendar days of the determination of the amount by the Department in accordance with Title 9, California Code of Regulations (CCR), Section 181**0.330,** or the enactment of the State Budget for the fiscal year, whichever is later.

6. Payment in Full

The amount payable under Item **4,** referred to hereafter as the allocation amount, constitutes payment in full by the Department of the State matching funds on behalf of beneficiaries for all covered services and for all utilization review and administrative costs incurred by the Contractor in providing or arranging for such services, except for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits.

State matching funds, in addition to the amount payable under Item **4,** for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits shall be paid in accordance with the Interagency Agreement between the Department and the State Department of Health Services (DHS 02-25271; DMH 02-72210-000 or subsequent agreement), which provides the federal financial participation and specified state matching funds for the Medi-Cal specialty mental health services and related activities

7. Determination of Allocation Amount

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

8. Renegotiation or Adiustment of Allocation Amount

A. To the extent permitted by federal law, either the Department or the Contractor may request that contract negotiations of the allocation amount be reopened during the course of a contract due to substantial

changes in the cost of covered services or related obligations that result from new legislative requirements affecting the scope of services or eligible population, or other unanticipated event. Any change in the allocation amount under this section is subject to the availability of funds. Any change in allocation amount shall be retroactive to the effective date of the change authorizing the amendment. 0429

B. The allocation amount may be changed pursuant to a change in the obligation of the Contractor as a result of a change in the obligations of a Medi-Cal managed care plan for services that would be covered by the Contractor if they were not covered by the Medi-Cal managed care plan, pursuant to Title 9, CCR, Section 1810.345 and Section 1810.350(a)(5). Any change in allocation amount shall be retroactive to the effective date of the change authorizing the amendment.

9. Disallowances and Offsets

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

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

10. Federal Financial Participation

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

EXHIBIT D
SPECIAL PROVISIONS

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1. Fulfillment of Obligation

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

2. Amendment of Contract

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

3. Contract Disputes

Should a dispute arise between the Contractor and the Department relating to performance under this contract other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, Title 9, California Code of Regulations (CCR), the Contractor shall, prior to exercising any other remedy which may be available, provide the

Department with written notice of the particulars of the dispute within 30 calendar days of the dispute. The Department shall meet with the Contractor, review the factors in the dispute, and recommend a means of resolving the dispute before a written response is given to the Contractor. The Department shall provide a written response to the Contractor within 30 days of receipt of the Contractor's written notice.

4. Inspection Rights

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

5. Notices

All notices to be given under this contract shall be in writing and shall be deemed to have been given when mailed, to the Department or the Contractor at the following addresses:

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

Santa Cruz County Mental Health
and Substance Abuse Services
Norm Wyman, MFT, Director
1400 Emeline Avenue
Santa Cruz, CA 95060

6. Confidentiality

A. The parties to this agreement shall comply with applicable laws and regulations, including but not limited to Section 5328 et seq. and Section 14100.2 of the Welfare and Institutions (W&I) Code and Title

42, Code of Federal Regulations (CFR), Section 431.300 et seq. and Exhibit E, Section 6, the HIPAA Business Associate Agreement regarding the confidentiality of beneficiary information.

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

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

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

7. Nondiscrimination

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

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

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

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

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8. Patients' Rights

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

9. Relationship of the Parties

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

10. Waiver of Default

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

11. Additional Contract Provisions

A. The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act (18 U.S.C. 874 and 40 U.S.C. 276c), which requires that all contracts and subcontracts in excess of $2000 for construction or repair awarded by the Contractor and its subcontractors shall include a provision for compliance with the Copeland Anti-Kickback Act (1*8* U.S.C. 874), as supplemented by Department of Labor regulations (Title 29, CFR, Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in part by Loans or Grants from the United States").

B. The Contractor shall comply with the provisions of Davis-Bacon Act, as amended (40 U.S.C. 276a to a-7), which requires that, when required

by Federal Medicaid program legislation, all construction contracts awarded by the Contractor and its subcontractors of more than $2,000 shall include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) as supplemented by Department of Labor regulations (Title 29, CFR, Part 5, "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction"), 0434

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

D. The Contractor shall comply with the provisions of Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended, which provide that contracts and subcontracts of amounts in excess of $100,000 shall contain a provision that requires the Contractor or subcontractor to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act and the Federal Water Pollution Control Act. Violations shall be reported to the Centers for Medicare and Medicaid Services.

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

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

EXHIBIT E
ADDITIONAL PROVISIONS

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SECTION 1 – GENERAL AUTHORITY

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

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

SECTION 2 – DEFINITIONS

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

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

B. "Contractor" means Santa Cruz County Mental Health and Substance Abuse Services.

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

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

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

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

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

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

1. A danger to self or others, or

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

I. "Facility" means any premises:

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

2. Maintained by a provider to provide covered services on behalf of the Contractor.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3 – GENERAL PROVISIONS

A. Governing Authorities

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

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

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

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

Title 42, Code of Federal Regulations (CFR);

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

Title 42, United States Code;

Title VI of the Civil Rights Act of 1964;

Title IX of the Education Amendments of 1972;

Age Discrimination Act of 1975;

Rehabilitation Act of 1973;

Titles II and III of the Americans with Disabilities Act; 0438

All other applicable laws and regulations; and

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

Any provision of this contract that is subsequently determined to be in conflict with the above laws, regulations, and agreements is hereby amended to conform to the provisions of those laws, regulations and agreements. Such amendment of the contract shall be effective on the effective date of the statutes, regulations or agreements necessitating it, and shall be binding on the parties hereto even though such amendment may not have been reduced to writing and formally agreed upon. and executed by the parties. Such amendment shall constitute grounds for termination of this contract, in accordance with the provisions of Section 4 and Title 9, CCR, Section 1810.325(d), if the Contractor determines it is unable or unwilling to comply with the provisions of such amendment. If the Contractor gives notice of termination to the Department, the parties shall not be bound by the terms of such amendment, commencing from the time notice of termination is received by the Department until the effective date of termination.

The full text of state regulations that are cited by section number in this contract is included as Exhibit E. Attachment 1. The full text of federal regulations that are cited by section number in this contract is included as Exhibit E, Attachment 2.

SECTION 4 – TERM AND TERMINATION

A. Contract Renewal

This contract may be renewed unless good cause is shown for nonrenewai pursuant to Title 9, CCR, Section 1810.320. Renewal shall be on an annual basis.

B. Contract Termination

The Department or the Contractor may terminate this contract in accordance with Title 9, CCR, Section 1810.325.

C. Mandatory Termination

The Department shall immediately terminate this contract in the event that the Director determines that there is an immediate threat to the health and safety of beneficiaries. The department shall terminate this contract in the event that the Secretary, HHS, determines that the contract does not meet the requirements for

participation in the Medicaid program, Title XIX of the Social Security Act. Terminations under this section shall be in accordance with Title 9, CCR, Section 1810.325.

D. Termination of Obligations

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

SECTION 5 - HIPAA BUSINESS ASSOCIATE AGREEMENT

The Contractor, referred to in this section as Business Associate, shall comply with, and assist the Department in complying with, the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), including but not limited to Title 42, United States Code, Section 1320d et seq. and its implementing regulations (including but not limited to Title 45, CFR, Parts 142, 160, 162, and 164), hereinafter collectively referred to as the "Privacy Rule." Terms used but not otherwise defined in this section shall have the same meaning as those terms are used in the Privacy Rule.

If the Department becomes aware of a pattern of activity that violates this section and reasonable steps to cure the violation are unsuccessful, the Department shall terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

A. Use and Disclosure of Protected Health Information

1. Except as otherwise provided in this section, Business Associate may use or disclose protected health information (PHI) to perform functions, activities or services for or on behalf of the Department, as specified in this contract, provided that such use or disclosure would not violate the Privacy Rule if done by the Department or the minimum necessary policies and procedures of the Department.

2. Except as otherwise limited in this section, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies

the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

3. Except as otherwise limited in this section, Business Associate may use PHI to provide data aggregation services related to the health care operation of the Department.

B. Further Disclosure of PHI

Business Associate shall not use or further disclose PHI other than as permitted or required by this section or as required by law.

C. Safeguard of PHI

Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this section.

D. Unauthorized Use or Disclosure of PHI

Business Associate shall report to the Department any use or disclosure of the PHI not provided for by this section.

E. Mitigation of Disallowed Uses and Disclosures

Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this section.

F. Agents and Subcontractors of the Business Associate

Business Associate shall ensure that any agent, including a subcontractor, to which the Business Associate provides PHI received from, or created or received by the Business Associate on behalf of the Department, shall comply with the same restrictions and conditions that apply through this section to the Business Associate with respect to such information.

G. Access to PHI

Business Associate shall provide access, at the request of the Department, and in the time and manner designated by the Department, to the Department or, as directed by the Department, to PHI in a designated record set to an individual in order to meet the requirements of Title 45, CFR, Section 164.524.

H. Amendment(s) to PHI

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Business Associate shall make any amendment(s) to PHI in a designated record set that the Department directs or at the request of the Department or an individual, and in the time and manner designated by the Department in accordance with Title 45, CFR, Section 164.526.

I. Documentation of Uses and Disclosures

Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for the Department to respond to a request by an individual for an accounting of disclosures of PHI in accordance with Title **45,** CFR, Section 164.528.

J. Accounting *of* Disclosure

Business Associate shall provide to the Department or an individual, in time and manner designated by the Department, information collected in accordance with Title 45, CFR, Section 164.528, to permit the Department to respond to a request by the individual for an accounting of disclosures of PHI in accordance with Title 45, CFR, Section 164.528.

K. Records Available to the Department and Secretary of HHS

Business Associate shall make internal practices, books and records related to the use, disclosure, and privacy protection of PHI received from the Department, or created or received by the Business Associate on behalf of the Department, available to the Department or to the Secretary of HHS for purposes of the Secretary determining the Department's compliance with the Privacy Rule, in a time and manner designed by the Department or the Secretary of HHS.

L. Retention, Transfer and Destruction of Information on Contract Termination

1. Upon termination of the contract for any reason, Business Associate shall retain all PHI received from the Department, or created or received by the Business Associate on behalf of the Department in accordance with Exhibit A, Attachment **1,** Section P of this contract in a manner that complies with the Privacy Rules. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate.

2. Prior to termination of the contract, the Business Associate may be required by the Department to provide copies of PHI to the Department in accordance with Exhibit A, Attachment 1, Section Q. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate.

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3. When the retention requirements on termination *of* the contract have been met, the Business Associate shall destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate. Business Associate, its agents or subcontractors shall retain no copies of the PHI.

4. In the event that Business Associate determines that destroying the PHI is not feasible, Business Associate shall provide the Department notification of the conditions that make destruction infeasible. Upon mutual agreement of the parties that the destruction of the PHI is not feasible, Business Associate shall extend the protections of this section to such PHI and limit further use and disclosures of such PHI for so long as Business Associate, or any of its agents or subcontractors, maintains such PHI.

M. Amendments to Section

The Parties agree to take such action as is necessary to amend this section as necessary for the Department to comply with the requirements of the Privacy Rule and its implementing regulations..

N. Material Breach

If the Department becomes aware of a pattern of activity that violates this section and reasonable steps to cure the violation are unsuccessful, the Department shall terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

O. Survival

The respective rights and obligations of Business Associate shall survive the termination of this contract.

P Interpretation

Any ambiguity in this section shall be resolved to permit the Department to comply with the Privacy Rule.

SECTION 6– DUTIES OF THE STATE

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

A. Payment for Services

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Pay the appropriate payments set forth in Exhibit B.

B. Reviews

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

C. Monitoring for Compliance

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

D. Approval Process

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

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

3. The Department shall act promptly to review requests from the Contractor for approval of subcontracts with providers that meet the conditions described in Title 9, CCR, Section 1810.438. The Department shall act to approve or disapprove the reimbursement and related claiming and cost reporting issues included in the

subcontract within 60 days of receipt of a request from the Contractor. If the Department disapproves the request, the Department shall provide the Contractor with the reasons for disapproval. 0444

E. Certification of Orqanizational Provider Sites Owned or Operated by the Contractor

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

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

The Department may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances.

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

F. Development and Distribution of Informinq Materials

a. Annually review the Contractor's beneficiary brochure and provider list for changes in federal and state laws and rules and changes to Contractor-specific information. If changes are required, develop the revised brochure and provider list and provide to the Contractor. The beneficiary brochure and provider list shall include the information required by Title 42, CFR, Section 438.10(f) and (g), including information specific to Contractor provided pursuant to Exhibit A,

Attachment 1, Section V. The informing materials shall meet the language and format standards required by Title 42, CFR, Section 438.10(c) and (d).

1) In addition to any requirements of Title 42, CFR, Section 438.10(f) and (g), the beneficiary brochure shall advise beneficiaries of the availability on request of a listing of cultural/linguistic services available through the Contractor.

2) In addition to any requirements of Title 42, CFR, Section 438.10(f) and (g), the provider list shall include information on the category or categories of services available from each provider. At a minimum the services available from the provider shall be categorized as psychiatric inpatient hospital services, targeted case management services and/or all other specialty mental health services. At the election of the Contractor, the list may include instructions to the beneficiary explaining how appointments may be scheduled and information on cultural and/or linguistic services available from the providers.

b. On a one-time basis, distribute a beneficiary brochure and provider list to all beneficiary households and all current clients as an initial distribution, including provider lists only in the distribution to current clients.

c. Distribute the most current beneficiary brochure developed pursuant to paragraph. a. to new beneficiaries on an ongoing basis.

d. Pursuant to Title 42, CFR, Section 438.10(f)(4), when there is a change in covered services under the contract, develop and distribute an update in the form of a beneficiary brochure insert and distribute to all Medi-Cal households and to the Contractor for inclusion in informing materials provided to new clients at least 30 days prior to the change. The Department shall work with the California Mental Health Directors Association to determine if notices of changes during the year outside the annual update process, in addition to notices related to changes in covered services under the contract, should be provided to beneficiaries.

e. Provide annual notice to all beneficiaries in accordance with Title 42, CFR, Section 438.10(f)(2).

G. Sanctions

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

H. Notification

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

I. Performance Measurement

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

J. Data Certification

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

SECTION 7 – SUBCONTRACTS

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

B. All subcontracts must be in writing.

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

D. Each subcontract must contain:

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

b. Specification of the services to be provided.

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

d. Specification of the term of the subcontract including the beginning and ending dates as well as methods for amendment, termination and, if applicable, extension of the subcontract.

e. The nondiscrimination and compliance provisions of this contract as described in Exhibit D, Section 7.

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

g. The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying by the Department, DHS, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives, at all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term *of* at least five years from the close of the Department's fiscal year in which the subcontract was in effect.

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

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

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

STATE REGULATIONS CROSS-REFERENCED IN CONTRACT

TITLE 9. CALIFORNIA CODE OF REGULATIONS
Chapter 11. Medi-Cal Specialty Mental Health Services

Subchapter 1. General Provisions
Article 2. Definitions, Abbreviations and Program Terms

1810.212. Day Rehabilitation.

"Day Rehabilitation" means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections *5777,* 14021.4, and 1.4684, Welfare and Institutions Code.

1810.213. Day Treatment Intensive.

"Day Treatment Intensive" means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections *5777,* 14021.4, and 14684, Welfare and Institutions Code.

1810.215. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services.

"EPSDT supplemental specialty mental health services" means those services defined in Title 22, Section 51184, that are provided to correct or ameliorate the diagnoses listed in Section 1830.205, and that are not otherwise covered by this chapter.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections *5777,* 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

1810.216. Emergency Psychiatric Condition.

"Emergency Psychiatric Condition" means a condition that meets the criteria in Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.216.1. Fair Hearing.

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, Sections 50951 and 50953.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 10950-10965 and 14684, Welfare and Institutions Code.

1810.218.2. Group Provider.

"Group Provider" means an organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.222. Individual Provider.

"Individual Provider" means licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage, family and child counselors, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.223. Licensed Mental Health Professional.

"Licensed mental health professional" means licensed physicians, licensed clinical psychologists, licensed clinical social workers, licensed marriage, family and child counselors, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.226. Mental Health Plan (MHP).

"Mental Health Plan" (MHP) means an entity which enters into an agreement with the department to arrange for andlor provide specialty mental health services to beneficiaries in a county as provided in this chapter. An MHP may be a county, counties acting jointly or another governmental or nongovernmental entity.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5777, 5778, and 14684, Welfare and Institutions Code.

1810.227. Mental Health Services.

"Mental Health Services" means those 'individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.4, and 14684, Welfare and Institutions Code.

1810.229. MHP Payment Authorization.

"MHP Payment Authorization" means the written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary. In addition to obtaining any required MHP payment authorization, the provider must meet all other applicable Medi-Cal requirements and requirements of the contract between the MHP and the provider to ensure reimbursement by the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.231. Organizational Provider.

"Organizational provider" means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waivered registered professionals and other staff. The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.237.1. Psychiatric Inpatient Hospital Professional Services.

"Psychiatric Inpatient Hospital Professional Services" means specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a psychiatric inpatient hospital. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.239. Psychiatric Nursing Facility Services.

"Psychiatric Nursing Facility Services" means skilled nursing facility services as defined in Title 22, Section 51123, that include special treatment program services for mentally disordered persons as defined in Chapter 3, Division 5, Title 22, provided by an entity that is licensed as a skilled nursing facility by the State Department of Health Services and is certified by the department to provide special treatment program services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code.

1810.247. Specialty Mental Health Services.

"Specialty Mental Health Services" means:

(a) Rehabilitative Services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.

(b) Psychiatric Inpatient Hospital Services;

(c) Targeted Case Management;

(d) Psychiatrist Services;

(e) Psychologist Services;

(f) EPSDT Supplemental Specialty Mental Health Services; and

(g) Psychiatric Nursing Facility Services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.3, 140214, 14132, and 14684, Welfare and Institutions Code.

1810.253. Urgent Condition.

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

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

1810.254. Waivered/Registered Professional.

"Waivered/Registered Professional" means an individual who has a waiver of psychologist licensure issued by the department or has registered with the applicable state licensing authority to obtain supervised clinical hours for Marriage, Family and Child Counselor or Clinical Social Worker licensure.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

Article **3.** Administration

1810.310. Implementation Plan.

(a) **An** entity designated as an MHP shall submit an Implementation Plan to the department, within the time frame established by the department. The time frame shall be no more than 180 days and no less than 90 calendar days prior to the date on which the entity proposes to begin operations. The Implementation Plan shall include:

(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.

(2) A description of the process for:

(A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.

(B) Outreach efforts for the purpose of providing information regarding access under the MHP to beneficiaries and providers.

(C) Assuring continuity of care for beneficiaries receiving specialty mental health services prior to the date the entity begins operation as the MHP.

(D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.

(3) A description of the processes for problem resolution as required in Subchapter 6.

(4) A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435. The MHP shall include a Request for Exemption from Contracting in accordance with Section 1810.430(c) if the MHP decides not to contract with a Traditional Hospital or DSH.

(5) **A** description of the provision, to the extent feasible, of age-appropriate services to beneficiaries.

(6) The MHP's proposed Cultural Competence Plan as described in Section 1810.410, unless the department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the department pursuant to Section 1810.410(c).

(7) **A** description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

(8) A description of the MHP's Quality Improvement and Utilization Management Programs.

(9) A description of policies and procedures that assure beneficiary confidentiality in compliance with applicable state and federal laws and regulations.

(10) Other policies and procedures identified by the department as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in this chapter.

(b) 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 applicant MHP entities within 60 calendar days of the receipt of the Implementation Plan.

(c) Prior to implementing changes in the policies, processes or procedures that modify its current Implementation Plan, an MHP shall submit its proposed changes in writing to the department for review. If the changes are consistent with this chapter, the changes shall be approved by the department. The department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within 30 calendar days after the receipt of the notice from the MHP. The MHP may implement the proposed changes 30 calendar days from submission to the department if the department fails to provide a Notice of Approval or Disapproval.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5777, 5778, 14683, and 14684, Welfare and Institutions Code.

1810.320. Contract Renewal.

(a)' A MHP contract shall be renewed unless good cause is shown for nonrenewal. The term of a renewed contract shall be one year. Good cause for nonrenewal shall include, but not be limited to the following:

(1) Failure of the MHP to comply with all terms and conditions of the contract and with all applicable laws and regulations.

(2) The department's finding of fact, based upon the MHP's past performance under its contract, that it does not have the ability to fulfill the terms of the contract with the State.

(b) The department shall have final discretionary authority in the renewal of the MHP contract.

(c) If either party chooses nonrenewal of the contract, then the MHP or the department must give to the other party at least 180 calendar days prior notice of nonrenewal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5777, and 5778, Welfare and. Institutions Code.

1810.325. Contract Termination.

(a) The MHP may terminate its contract with the department in accordance with the terms of its contract with the department by delivering written notice of termination to the department at least 180 calendar days prior to the effective date of termination.

(b) The department shall immediately terminate its contract with an MHP if the department finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries.

(c) The department shall terminate its contract with an MHP that the Secretary, Health and Human Services has determined does not meet the requirements for participation in the

Medicaid program, Title XIX of the Social Security Act. The department shall deliver written notice of termination to the MHP at least 60 calendar days prior to the proposed effective date of termination.

(d) The department may terminate the MHP contract for noncompliance with the requirements of law or regulations or terms of the contract. The department shall deliver written notice of termination to the MHP at least 90 calendar days prior to the proposed effective date of termination.

(e) The department may terminate its contract with an MHP for any reason not specified in subsections (b), (c), or (d) by delivering written notice of termination to the MHP at least 180 calendar days prior to the proposed effective date of termination.

(f) The written notice of termination shall be provided to the MHP and to other persons and organizations as the department may deem necessary.

(g) The written notice of termination shall include the reason for the termination and the proposed effective date of termination.

(h) The MHP may appeal, in writing, a proposed contract termination to the department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The department shall grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the department may take another action available under Section 1810.380(b). The department's election to take another action shall not be appealable to the department. Except for terminations pursuant to subsection (c), the department shall pend the termination date until the department has acted on the MHP's appeal.

(1) The MHP may request that a public hearing be held by the Office of Administrative Hearings to allow the department to show cause for the termination. The public hearing shall be held no later than 30 calendar days after receipt by the MHP of the notice to terminate the contract. In order to give the Office of Administrative Hearings sufficient time to arrange for a hearing, the MHP request for a hearing shall be submitted no later than five working days after receipt of the notice to terminate, by making its request to the Office of Administrative Hearings directly.

(2) The Office of Administrative Hearings shall provide written recommendations concerning the termination of the contract to the department and to the MHP within 30 calendar days after conclusion of the hearing. The department shall act to grant or deny the appeal within 30 calendar days after receipt of the recommendations of the Office of Administrative Hearings. In granting an appeal, the department may take another action available under Section 1810.380(b). The department's election to take another action shall not be appealable to the department or to the Office of Administrative Hearings. Except for terminations pursuant to subsection (c), the department shall pend the termination date until the department has acted on the MHP's appeal.

(i) In the event that the contract with an MHP is terminated for any cause, the remaining balance of State funds which were transferred to the MHP for specialty mental health services shall be returned to the department on a timeline specified by the department in the notice of termination. The State has a right to examine all records of an MHP to determine the balance of funds to be returned to the department.

NOTE: Authority cited.: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5776, 5777, 5778, and 5780, Welfare and Institutions Code.

1810.330. Allocation of State Funds to MHPs.

In consultation with a statewide organization representing counties, the department shall determine the methodology for allocating state funds to the MHPs annually. The methodology shall include a determination of the appropriate level for the Small County Reserve allocation. The allocation shall include state funds for specialty mental health services covered by the MHP that are not eligible for federal financial participation pursuant to Subchapter 4, subject to the appropriation of such funds by the legislature. State funds based on the allocation process shall be provided *to* each MHP annually in accordance with the terms of its contract with the department and to the Small County Reserve, if applicable.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 5778, Welfare and Institutions Code,

1810.345. Scope of Covered Specialty Mental Health Services.

(a) The MHP of a beneficiary shall provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. Except as provided elsewhere in this chapter, the MHP shall not be required to provide or arrange for any specific specialty mental health service, but shall ensure that the specialty mental health services available are adequate to meet the needs of the beneficiary as described in the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 as applicable. The MHP of a beneficiary shall be required to provide specialty mental health services only to the extent the beneficiary is eligible for those services based on the beneficiary's Medi-Cal eligibility under Title 22, Division 3, Subdivision 1, Chapter 2, Article 5 and Article 7.

(b) The department may exclude psychiatric nursing facility services from the specialty mental health services covered by the MHP until the department determines that all necessary systems are in place at the State level to ensure proper payment of the providers of psychiatric nursing facility services and proper claiming of federal funds pursuant to Subchapter 4. The department shall adjust the contract between the MHP and the department and the allocation to the MHP pursuant to Section 1810.330 to reflect the exclusion and inclusion of these services as appropriate.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5775, 5777, 14007.5, 14011, 14142, 14145, 14682, Welfare and Institutions Code.

1810.350. Scope **of** Covered Psychiatric Inpatient Hospital Services.

(a) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services as described in Section 1810.345 and in (b) and (c).

(b) Psychiatric Inpatient Hospital Services for a Fee-for-ServiceMedi-Cal hospital shall include:

(1) Routine hospital services and

(2) All hospital-based ancillary services.

(c) Psychiatric Inpatient Hospital Services for a Short-Doyle/Medi-Cal hospital shall include:

(1) Routine hospital Services,

(2) **All** hospital-based ancillary services, and

(3) Psychiatric inpatient hospital professional services.

(d) **An** MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services provided to a beneficiary eligible for Medicare (Part **A)** if the payment being authorized is for administrative day services following any approved acute psychiatric inpatient hospital services day and there is compliance with Section 1820.220(j)(5).

NOTE: Authority cited: Section 14680, Welfare and institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.360. Notification **of** Beneficiaries.

(a) Prior to ttie date the MHP begins operations, the department shall mail a notice to all beneficiaries in a county containing the following information:

(1) The date the MHP will begin operation.

(2) The name and statewide, toll-free telephone number of the MHP.

(3) The availability of a brochure and provider list from the **MHP** upon request.

(b) The department shall ensure that the notice described in subsection (a) is provided to new beneficiaries either through the mail, through the Medi-Cal eligibility determination process, or through other appropriate means.

(c) The MHP of the beneficiary shall provide beneficiaries with a brochure upon request or when a beneficiary first accesses services. The beneficiary brochure shall contain the following information:

(1) A description of the services available.

(2) A description of the process for obtaining services, including the MHP's statewide toll-free telephone number.

(3) A description of the MHP's beneficiary problem resolution process, including the complaint resolution and grievance processes and the availability of fair hearings.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 14683, Welfare and Institutions Code.

1810.365. Beneficiary Billing.

(a) The MHP of a beneficiary, or an affiliate, vendor, contractor, or sub-subcontractor of the MHP shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this chapter except to collect:

(1) Other health care coverage pursuant to Title 22, Section 51005.

(2) Share of cost as provided in Title 22, Sections 50657 through 50659.

(3) Copayments in accordance with Welfare and Institutions Code, Section 14134, and Title 22, Section 51004.

(b) In the event that a beneficiary willfully refuses to provide other current health insurance coverage billing information as described in Title 22, Section 50763(a)(5) to a provider, including the MHP, upon giving the beneficiary written notice of intent, the provider may bill the beneficiary as a private pay patient.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14005.9, 14024, and 14134, Welfare and Institutions Code.

1810.370. MOUs with Medi-Cal Managed Care Plans.

(a) The MHP shall enter into an MOU with any Medi-Cal Managed Care Plan that enrolls beneficiaries covered by the MHP. The MOU shall, at a minimum, address the following:

(1) Referral protocols between plans, including how the MHP will provide areferral to the Medi-Cal managed care plan when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment and how the Medi-Cal managed care plan will provide a referral when the Medi-Cat managed care plan determines specialty mental health services covered by the MHP may be required.

(2) The availability of clinical consultation, including consultation on medications, to the Medi-cal managed care plan for beneficiaries whose mental illness is being treated by the Medi-Cal managed care plan.

(3) Appropriate management of a beneficiary's care, including procedures for the exchange of medical records information, which maintain confidentiality in accordance with applicable state and federal laws and regulations. The procedures shall ensure that the confidentiality of medical records is maintained in accordance with applicable state and federal laws and regulations.

(4) Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP when those necessary services are covered by the Medi-Cal managed care plan. The procedures shall address, but are not limited to:

(A) Prescription drugs and laboratory services covered by the Medi-Cal managed care plan and prescribed through the MHP. Prescription drug and laboratory service procedures shall include:

1. The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Medi-Cal managed care plan, if the Medi-Cat managed care plan covers .prescription drugs.

2. The Medi-Cal managed care plan's obligation to provide the Medi-Cal managed care plan's procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP, if the Medi-Cal managed care plan covers these services.

(B) Emergency room facility and related services other than specialty mental health services, home health services, non-emergency medical transportation, and services to treat the physical health care needs of beneficiaries who are inpatients in a psychiatric inpatient hospital, including the history and physical required upon admission.

(C) Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's medical problems based on changes in the beneficiary' mental health or medical condition.

(5) A process for resolving disputes between the MHP and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services and prescription drugs, while the dispute is being resolved.

(b) If the MHP does not enter into an MOU with the Medi-Cal managed care plan, the MHP shall not be out of compliance with this section provided the MHP establishes to the satisfaction of the department that it has made good faith efforts to enter into an MOU.

(c) When enrollment in a Medi-Cal managed care plan in any county is 2000 beneficiaries or less, the department shall, at the request of the MHP or the Medi-Cal managed care plan, grant a waiver from the requirements of this section provided both plans provide assurance that beneficiary care will be coordinated in compliance with Section 1810.41**5.**

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
'Reference: Section 14681, Welfare and Institutions Code.

1810.380. State Oversight.

(a) The department shall provide ongoing oversight to an MHP through site visits and monitoring of data reports from MHPs and claims processing. In addition, the department shall:

(1) Perform reviews of program and fiscal operations of each MHP to verify that medically necessary services are provided in compliance with this chapter and the provisions of the approved federal waiver for Medi-Cal Specialty Mental Health Services Consolidation.

(2) Perform immediate on-site reviews of MHP program operations whenever the department obtains information indicating that there is a threat to the health or safety of beneficiaries.

(3) Monitor compliance with problem resolution process requirements contained in , Subchapter 5 and the MHP's Implementation Plan.

(4) Monitor provider contracts to ensure that the MHP enters into necessary contracts with DSH and Traditional Hospitals.

(5) Monitor denials of MHP payment authorizations.

(b) If the department determines that an MHP is out of compliance with State or Federal laws and regulations, the department may take any or all of the following actions:

(1) Require that the MHP develop a plan of correction.

(2) Withhold all or a portion of payments due to the MHP from the department.

(3) Impose civil penalties pursuant to Section 1810.385.

(4) Require that the MHP meet reporting, access to care, quality of care, provider reimbursement, and beneficiary and provider problem resolution process requirements that exceed the requirements of this chapter.

(5) Terminate the contract with the MHP pursuant to Section 1810.325.

(6) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

(c) If the department determines that an action should be taken pursuant to subsection (b), the department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation.

(2) A description of any corrective action required by the department and time limits for compliance.

(3) A description of any and all proposed actions by the department under this section, Section 1810.385, or Section 1810.325 and any related appeal rights.

(d) Except as provided in Section 1810.325, the MHP may appeal the Notice of Noncompliance to the department, in writing, within 15 working days after the receipt of the notice, setting forth relevant facts and arguments. The department shall grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. The department shall pend any proposed action pursuant to subsection (c)(3) until the department has acted on the MHP's appeal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and institutions Code.

1810.385. Civil Penalties.

(a) The department may impose one or more of the civil penalties specified in (b) upon an MHP which fails to comply with the provisions of Part 2.5, Division 5, and Articles 4 and 5, Chapter 8.8, Part 3, Division 9, Welfare and Institutions Code, the provisions of this chapter, or the terms of the MHP's contract with the department.

(b) Civil penalties imposed by the department shall be in the amounts specified below with respect to violation of:

(1) The provisions of Section 1810.350, "Notification of Beneficiaries", Section 1850.205, "Beneficiary Problem Resolution Processes", Section 1850.210, "Fair Hearing and Notice of

Action", and Section 1850.215, "Medical Assistance for Beneficiary Pending Fair Hearing Decision",

(A) First violation: $1,000.

(B) Second and each subsequent violation: $5,000.

(2) The provisions of Section 1810.375, "MHP Reporting", and any other regulation or contract provision establishing a time frame for action.

(A) First violation: $500, plus $25 per day for each day that the item to be submitted is late.

(B) Second and each subsequent violation: $500, plus $25 per day for each day that the item to be submitted is late.

(3) Any provision of this chapter which is not specifically addressed in this section.

(A) First violation: $500.

(B) Second violation: $1,000.

(C) Third and each subsequent violation: $5,000.

(4) Any provision of the contract between the MHP and the department which is not specifically governed by regulation in this chapter.

(A) First violation: $500.

(B) Second and subsequent violations: $1,000.

(5) Any provision of Part 2.5, Division 5, and Articles **4** and 5, Chapter 8.8, Part 3, Division 9, Welfare and Institutions Code, which is not specifically addressed by regulations in this chapter.

(A) First violation: $1,000.

(B) Second and subsequent violations: $1,000.

(c) When the department issues a notice of noncompliance as described in Section 1810.380 to an MHP found by the department to be in violation of any provision of law, regulation or the contract, failure to comply with corrective actions in the notice within the time limits given shall be deemed to be a subsequent violation under this section.

NOTE: Authority: Sections 5775(e)(1) and 14680, Welfare and Institutions Code.

Reference: Sections 5775(e)(1) and 5777, Welfare and Institutions Code.

Article 4. Standards

1810.405. Access Standards for Specialty Mental Health Services.

(a) The MHP of the beneficiary shall be responsible for assuring that the beneficiary has access to specialty mental health services as provided in Section 1810.345 and Section 1810.350.

(b) Referrals to the MHP for Specialty Mental Health Services may be received through beneficiary self referral or through referral by another person or organization, including but not limited to:

(1) Physical health care providers

(2) Schools

(3) County welfare departments

(4) Other MHPs.

(5) Conservators, guardians, or family members.

(6) Law enforcement agencies.

(c) Each MHP shall make specialty mental health services to treat a beneficiary's urgent condition available 24 hours a day, seven days per week. If the MHP requires that a provider obtain approval of an MHP payment authorization request prior to the delivery of a specialty mental health service to treat a beneficiary's urgent condition as a condition of payment to the provider, the MHP shall have a statewide, toll-free telephone number available 24 hours a day, seven days per week, to act on MHP payment authorization requests for specialty mental health services to treat a beneficiary's urgent condition. Under these circumstances, the MHP shall act on the MHP payment authorization request within one hour of the request.

(d) Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in the languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access specialty mental health services, including services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

(e) At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity

criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

(f) The MHP shall maintain a written log of the initial requests for specialty mental health services from beneficiaries of the MHP. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1810.410 Cultural and Linguistic Requirements.

(a) Each MHP shall comply with the cultural competence and linguistic requirements included in this section, the terms of the contract between the MHP and the department, and the MHP's Cultural Competence Plan established pursuant to subsection (b). The terms of the contract between the MHP and the department may provide additional requirements for the Cultural Competence Plan, including a description of the acceptable data sources and requirements for arraying data for the Components of the Cultural Competence Plan.

(b) Each MHP shall develop and implement a Cultural Competence Plan which includes the following components:

(1) Objectives and strategies for improving the MHP's cultural competence based on the assessments required in subsections (b)(2) and the MHP's performance on the standards in subsections (d).

(2) **A** population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability.

(3) **A** listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services.

(4) **A** plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

(c) The department shall establish timelines for the submission and review of the Cultural Competence Plan described in subsection (b) either as a component of the Implementation Plan process described in 'Section 1810.310 or **as** a term of the contract between the MHP and

the department. The MHP shall submit the Cultural Competence Plan to the department for review and approval in accordance with these timelines. The MHP shall update the Cultural Competence Plan and submit these updates to the department for review and approval annually.

(d) Each MHP shall provide:

(1) A statewide, toll-free telephone number available 24 hours a day, seven days a week, with language capability in all the languages spoken by the beneficiaries of the MHP as required by Section 1810.405(d).

(2) Interpreter services in threshold languages at key points *of* contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points *of* contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

(A) The MHP has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it *is* not; and

(B) The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the applicable area, to a key point of contact that does have interpreter services in that threshold language.

(3) General program, literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure required by Section 1810.360(c), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and health education materials used by the MHP, in threshold languages, based on the threshold languages in the county as a whole.

(e) In consultation with representatives from MHPs, beneficiaries, and community-based diverse cultural and linguistic groups, the department shall develop, and update as appropriate, a set of comprehensive cultural and linguistic requirements which may be incorporated into regulation as changes to Cultural Competence Plan requirements or as specific standards or into the contract between the department and each MHP.

(f) Definitions:

(1) "Key points of contact" means common points of access to specialty mental health services from the MHP, including the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.

(2) "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

(3) "Threshold Language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5777, 5778, 14684, Welfare and Institutions Code.

1810.435. MHP Individual, Group and Organizational Provider Selection Criteria.

(a) Each MHP shall establish individual, group, and organizational provider selection criteria that comply with the requirements of this section, the terms of the contract between the MHP and the department, and the MHP's Implementation Plan pursuant to Section 1810.310.

(b) In selecting individual or group providers with which to contract, the MHP shall require that each individual or group provider:

(1) Possess the necessary license or certification to practice psychotherapy independently. Each individual practicing as part of a group provider shall possess the necessary license or certification.

(2) Maintain a safe facility.

(3) Store and dispense medications in compliance with all applicable state and federal laws and regulations.

(4) Maintain client records in a manner that meets state and federal standards.

(5) Meet the MHP's Quality Management Program standards.

(6) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(c) In selecting organizational providers with which to contract, the MHP shall require that each provider:

(1) Possess the necessary license *to* operate.

(2) Provide for appropriate supervision of staff.

(3) Have as head of service a licensed mental health professional or other appropriate individual as described in Sections 622 through 630.

(4) Possess appropriate liability insurance.

(5) Maintain a safe facility.

(6) Store and dispense medications in compliance with all pertinent state and federal standards.

(7) Maintain client records in a manner that meets state and federal standards.

(8) Meet the MHP's Quality Management Program standards and requirements.

(9) Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to Section 1840.105.

(10) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(d) The MHP shall certify that a provider other than the MHP meets the applicable criteria in subsections (b) or (c) prior to the provision of specialty mental health services under this chapter, unless another time frame is provided in the contract between the department and the MHP. For organizational providers, the MHP's certification process shall include an on site review in addition to a review of relevant documentation.

(e) When an organizational provider is the MHP, the department shall certify that each specific office or facility owned or operated by the MHP meets the applicable criteria in subsections (b), (c), or the contract between the department and the MHP. Unless another time frame is provided in the contract between the department and the MHP, the department's certification shall be obtained by the MHP prior to use of the provider for the provision of specialty mental health services under this chapter. The department's certification process shall include an on-site review of the office or facility in addition to a review of relevant documentation.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 5777 and 14684, Welfare and Institutions Code

1810.438 Alternative 'Contracts between MHPs and Providers.

(a) The MHP shall request approval from the department to establish a contract with a provider for specialty mental health services where that provider is held financially responsible for specialty mental health services provided to beneficiaries by one or more other providers.

(b) The MHP may request approval from the department under this section by submitting a written request to the department containing a description of:

(1) The proposed contract terms concerning reimbursement,

(2) A complete description of the administrative system of the provider and the MHP that will ensure proper payment to the provider, claiming of the FFP available for services provided to Medi-Cal beneficiaries under the Medi-Cal program, and MHP cost report settlement.

(c) The MHP shall not implement the proposed contract terms until written approval by the department is received. The department shall review the proposal and approve the request only if the following conditions are met:

(1) The proposed contract complies with federal and state requirements for reimbursement for specialty mental health services.

(2) The MHP has established appropriate systems to prevent duplicate claiming of FFP.

(3) The MHP has established appropriate procedures to assure that services provided under the contract are reported by only one provider in cost and data reporting to the department.

(d) Nothing in this section shall exclude or exempt a provider from compliance with any applicable licensing requirements for health care service plans and specialized health care service plans under Health and Safety Code, Section 1340 et seq.

(e) For contracts executed before November 1, 1997 that meet the criteria of subsection (a) the MHP shall request approval from the department no later than July 1, 1998 or the date the contract is amended to change the reimbursement method, whichever is earlier. Nothing in this subsection shall preclude the department from reviewing any contracts for compliance with other applicable laws and regulations pursuant to Section 1810.380.

(f) A negotiated rate of payment between an MHP and a provider pursuant to this section shall not be the basis for finding a violation of the requirements of Title 22, Section 51501(a) or Section 51480 and shall not be the basis for otherwise reducing the provider's reimbursement pursuant to Title 22, Division 3, Subdivision 1, Chapter 3, Article 7.

NOTE: Authority cited: Section 14680, Welfare and institutions Code.
Reference: Section 1340 et seq., Health and Safety Code, and Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1810.440. MHP Quality Management Programs.

The MHP shall establish a Quality Management Program in accordance with the terms of the contract between the MHP and the department that includes at least the following elements:

(a) A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries by the MHP that:

(1) Is accountable to the director of the MHP.

(2) Has active involvement in planning, design and execution from:

(A) Providers;

(B) Beneficiaries who have accessed specialty mental health services through the MHP; and

(C) Parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.

(3) Includes substantial involvement of a licensed mental health professional.

(4) Conducts monitoring activities including but not limited to review of beneficiary complaints and grievances and fair hearings, provider appeals, and clinical records review.

(5) Is reviewed by the MHP and revised as appropriate annually.

(b) A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP that:

(1) Assures that the access and authorization criteria established in this chapter are met.

(2) Conducts monitoring activities to ensure that the MHP meets the established standards for authorization decision making and takes action to improve performance if necessary.

(3) Is reviewed by the MHP and revised as appropriate annually.

(c) A beneficiary documentation and medical record system that meets the requirements of the contract between the MHP and the department and any appticable requirements of state and federal law and regulation.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections *5777,* 14683, and 14684, Welfare and Institutions Code.

Subchapter 2. Medi-Cal Psychiatric Inpatient Hospital Services.
Article 2. Provision of Services.

1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy or Early Childhood

(D) Tic Disorders

(E) Elimination Disorders

(F) Other Disorders of Infancy, Childhood, or Adolescence

(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)

(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder

(I) Schizophrenia and Other Psychotic Disorders

(J) Mood Disorders

(K) Anxiety Disorders

(L) Somatoform Disorders

(M) Dissociative Disorders

(N) Eating Disorders

(O) Intermittent Explosive Disorder

(P) Pyromania

(Q) Adjustment Disorders

(R) Personality Disorders

(2) A beneficiary must have both **(A)** and (B):

(A) Cannot be safely treated at a lower level of care; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.

b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications which meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications which meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

(G) An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777,5778, and 14684, Welfare and Institutions Code.

1820.215. MHP Payment Authorization - General Provisions.

(a) The MHP payment authorization shall be determined for

(1) Fee-for-Service/Medi-Cal hospitals, by an MHP's Point of Authorization.

(2) For Short-Doyle/Medi-Cal hospitals contracting with the MHP, by either:

(A) An MHP's Point of Authorization, or

(B) The hospital's Utilization Review Committee, as agreed to in the contract.

(3) For Short-Doyle/Medi-Cal hospitals that do not have a contract with the MHP, by an MHP's Point of Authorization.

(b) The MHP that approves the MHP payment authorization shall have financial responsibility as described in this chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Sections 1850.405 and 1850.505 or unless the services are provided to individuals eligible for the County Medical Services Program. Services provided to individuals eligible for the County Medical Services Program shall be authorized by the MHP for that county, but the MHP will not be responsible for payment of those services.

(c) MHP payment authorization requests presented for authorization beyond the timelines specified in this subchapter shall be accepted for consideration by the MHP only when the MHP determines that the hospital was prevented from submitting a timely request because of a reason that meets one of the criteria specified in subsections (1) and *(2).* The hospital shall submit factual documentation deemed necessary by the MHP with the MHP payment authorization request. Any additional documentation requested by the MHP shall be submitted within 60 calendar days of the MHP's request. The documentation shall verify that the late submission was due to:

(1) A natural disaster which has:

(A) Destroyed or damaged the hospital's business office or records, or

(B) Substantially interfered with the hospital's agent's processing of requests for MHP payment authorization; or

(2) Delays caused by other circumstances beyond the hospital's control which have been reported to an appropriate law enforcement or fire agency when applicable. Circumstances which shall not be considered beyond the control of the hospital include but are not limited to:

(A) Negligence by employees.

(B) Misunderstanding of program requirements.

(C) Illness or absence of any employee trained to prepare MHP payment authorizations.

(D) Delays caused by the United States Postal Service or any private delivery service.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.220. MHP Payment Authorization by a Point of Authorization.

(a) A hospital shall submit a separate written request for MHP payment authorization of psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP for each of the following:

(1) The planned admission of a beneficiary.

(2) Ninety-nine calendar days of continuous service to a beneficiary, if the hospital stay exceeds that period of time.

(3) Upon discharge.

(4) Services that qualify for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(5) Administrative day services that are requested for a beneficiary.

(b) A hospital shall submit the request for MHP payment authorization for psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission.

(2) Within 14 calendar days after :

(A) Ninety-nine calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time.

(B) Discharge.

(C) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(c) A written request for MHP payment authorization to the Point of Authorization shall be in the form of:

(1) A Treatment Authorization Request (TAR) for Fee-for-Service/Medi-Cal hospitals; or

(2) As specified by the MHP for Short-Doyle/Medi-Cal hospitals.

(d) The Point of Authorization staff that approve or deny payment shall be licensed mental health or waiveredlregistered professionals of the beneficiary's MHP.

(e) Approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing:

(I) On the same TAR on which the Fee-for-Service/ Medi-Cal hospital requested MHP payment authorization or

(2) in an MHP payment authorization log maintained by the MHP for Short-Doyle/Medi-Cal hospitals.

(f) The MHP shall document that all adverse decisions regarding hospital requests for MHP payment authorization based on medical necessity criteria or the criteria for emergency admission were reviewed and approved:

(1) by a physician, or

(2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under hislher scope *of* practice.

(g) A request for an MHP payment authorization may be denied by a Point of Authorization if the request is not submitted in accordance with timelines in this subchapter or does not meet applicable medical necessity reimbursement criteria or emergency psychiatric condition criteria on an emergency admission or if the hospital has failed to meet any other mandatory requirements of the contract negotiated between the hospital and the MHP.

(h) A Point of Authorization shall approve or deny the request for MHP payment authorization within 14 calendar days of the receipt of the request **and,** for a request from a Fee-for-Service Medi-Cal hospital, shall submit the TAR to the fiscal intermediary within 14 calendar days of approval or denial.

(i) Point of Authorization staff may authorize payments for up to seven calendar days **in** advance of service provision.

(j) Approval of the MHP payment authorization by a Point of Authorization requires that:

(1) Planned admission requests for an MHP's payment authorization shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services, as specified in Section 1820.205, any other applicable requirements of this subchapter, and any mandatory requirements of the contract negotiated between the hospital and the MHP. The request shall be submitted and approved prior to admission.

(2) Emergency admissions shall not be subject to prior MHP payment authorization.

(3) A request for MHP payment authorization for continued stay services shall be submitted to the Point of Authorization as follows:

(A) A contract hospital's request shall be submitted within the timelines specified in the contract. If the contract does not specify tielines, the contract hospital shall be subject to the same timeline requirements as the non-contract hospitals.

(B) A non-contract hospital's request shall be submitted to the Point of Authorization not later than:

1. Within 14 calendar days after the beneficiary is discharged from the hospital, or

2. Within 14 calendar days after a beneficiary has received 99 continuous calendar days of psychiatric inpatient hospital services

(4) Requests for MHP payment authorization for continued stay services shall be approved if written documentation has been provided to the MHP indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of service in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP.

(5) Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

(A) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

(C) For beneficiaries also eligible under Medicare (Part **A)** who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage, the hospital has notified the Point of Authorization within 24 hours or as specified in the contract, prior to beginning administrative day services.

(6) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a hospital shall be approved by an MHP when necessary documentation, as specified in Section 1850.215, is submitted.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections *5777,* 5778, and 14684, Welfare and Institutions Code.

1820.225. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

(a) The MHP shall not require a hospital to obtain prior MHP payment authorization for an emergency admission, whether voluntary or involuntary.

(b) The hospital providing emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in Section 1820.205, and due to a mental disorder, is:

(1) A danger to self or others, or

(2) Immediately unable to provide for, or utilize, food, shelter or clothing.

(c) The hospital providing emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within 24 hours of the time of the admission of the beneficiary to the hospital, or within the timelines specified in the contract, if applicable.

(1) If the hospital cannot determine the MHP of the beneficiary, the hospital shall notify the MHP of the county where the hospital is located, within 24 hours of admission.

(2) The MHP for the county where the hospital is located shall assist the hospital to determine the MHP of the beneficiary. The hospital shall notify the MHP of the beneficiary within 24 hours of determination of the appropriate MHP.

(d) Requests for MHP payment authorization for an emergency admission shall be approved by an MHP when:

(1) A hospital notified the Point of Authorization within 24 hours of admission of a beneficiary to the hospital or within the time required by contract, if applicable.

(2) Written documentation has been provided to the MHP that certifies that a beneficiary met the criteria in (b) at the time of admission.

(3) Written documentation has been provided to the MHP that certifies a beneficiary met the criteria in (b) for the day of admission.

(4) A non-contract hospital includes documentation that the beneficiary could not be safely transferred to a contract hospital or a hospital owned or operated by the MHP of the beneficiary, if the transfer was requested by the MHP.

(5) Any mandatory requirements of the contract negotiated between the hospital and the MHP are met.

(e) After an emergency admission, the MHP of the beneficiary may:

(1) Transfer the beneficiary from a non-contract to a contract hospital or a hospital owned or operated by the MHP of the beneficiary as soon as it is safe to do so. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

(2) Choose to authorize continued stay with a non-contract hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.230. MHP Payment Authorization by a Utilization Review Committee.

(a) MHP payment authorization for psychiatric inpatient hospital services provided by a Short-Doyle/Medi-Cal hospital, if not made by an MHP's Point of Authorization pursuant to Section 1820.220, shall be made by the hospital's Utilization Review Committee.

(1) The hospital's Utilization Review Committee shall meet the Federal requirements for participants pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart **D.**

(2) The decision regarding MHP payment authorization shall be documented in writing by the hospital's Utilization Review Committee.

(b) The hospital's Utilization Review committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission.

(c) At the time of the initial MHP payment authorization, the hospital's Utilization Review Committee or its designee shall specify the date for the subsequent MHP payment authorization determination.

(d) Approval of MHP payment authorization by a hospital's Utilization Review Committee requires that:

(1) When documentation in the clinical record substantiates that the beneficiary met the medical necessity criteria, the hospital's Utilization Review Committee shall authorize payment for each day that services are provided.

(2) Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week for placement of the beneficiary subject *to* the following requirements.

1. The MHP or its designee can waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented *to* include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

Subchapter 3. Specialty Mental Health Services Other Than Psychiatric Inpatient Hospital Services.
Article 2. Provision of Services.

1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cat reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E). Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(Gj Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d(r), United States Code.

1830.215. MHP Payment Authorization.

(a) Except as provided in Sections 1830.245 and 1830.250, the MHP may require that providers obtain MHP payment authorization of any or all specialty mental health services covered by this subchapter as a condition of reimbursement for the service.

(1) The MHP's authorization function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization function; including any such persons or entities affiliated with a contracting provider to which the MHP has delegated the authorization function.

(2) The individuals who review and approve or deny requests from providers for MHP payment authorization shall be licensed mental health professionals or waiveredlregistered professionals of the MHP of the beneficiary. Licensed psychiatric technicians and licensed vocational nurses may approve or deny such requests only when the provider indicates that the beneficiary to whom the specialty mental health services will be delivered has an urgent condition.

(b) The MHP may require that providers obtain MHP payment authorization prior to rendering any specialty mental health service covered by this subchapter as a condition of reimbursement for the service, except for those services provided to beneficiaries with emergency psychiatric conditions as provided in Sections 1830.230 and 1830.245.

(c) Notwithstanding the provisions of subsections (a) and (b), the MHP shall require that providers obtain MHP payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services as required in the MHP contract with the Department, and in compliance with Title 42, Code of Federal Regulations (CFR) Part 438, Section 438.210, Subsections (a) and (b), as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Pages 41107 and 41108), which is hereby incorporated by reference.

(d) Whether or not the MHP payment authorization of a specialty mental health service is required pursuant to subsections (a) or (b), the MHP may require that providers notify the MHP of their intent to provide the service prior to the delivery of the service. If the MHP does require such notice, the MHP shall inform providers of this requirement by including the MHP requirement in a publication commonly available to all providers serving beneficiaries.

NOTE: Authority cited: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code. Reference: Sections 5718, 5767, 5776, 5777, 5778 and 14684, Welfare and Institutions Code; and 42 CFR Part 438, Section 438.210(a) and (b). (Amended to add new subsection (c) effective 7/1/03.)

1830.220. Authorization of Out-of-Plan Services.

(a) "Out-of-Plan Services" means specialty mental health services covered by this subchapter, other than psychiatric nursing facility services, provided to a beneficiary by providers other than the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary.

(b) The MHP shall be required to provide out-of-plan services only under the following circumstances:

(1) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services as described in Section 1820.225 to the extent provided in Section 1830.230.

(2) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric health facility services under the conditions described in Section 1830.245.

(3) When a beneficiary is out of county and develops an urgent condition and there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, especially in terms of timeliness of service.

(4) When there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, the geographic availability of providers, and community standards for availability of providers in the county in which the beneficiary is placed and the beneficiary is placed out of county by:

(A) The Foster Care Program as described in Article 5 (commencing with Section 11400), Chapter 2. Part 3, Division *9* of the Welfare and Institutions Code, the Adoption Assistance Program as described in Chapter 2.1 (commencing with Section 16115), Part 4, Division **9** of the Welfare and Institutions Code, or other foster care arrangement,

(B) A Lanterman-Petris-Short or Probate Conservator or other legal involuntary placement.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 11400, 14684, and 16115, Welfare and Institutions Code.

1830.225. Initial Selection and Change *of* Person Providing Services.

(a) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide a beneficiary who has been determined by the MHP to meet the medical necessity criteria for outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative or targeted case management services an initial choice of the person who will provide the service to the beneficiary. The MHP may limit the beneficiary's choice, at the election of the MHP, to a choice between two of the individual providers contracting with the MHP or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

(b) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative, or targeted case management services. The MHP may limit the beneficiary's choice of another person to provide services, at the election of the MHP, to an individual provider contracting with the MHP or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary,

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.

Reference: Sections 5777, 14681, 14683, and 14684, Welfare and Institutions Code.

Subchapter 4. Federal Financial Participation.
Article 1 General

1840.112. MHP Claims Certification and Program Integrity.

(a) Each MHP shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

(b) Each MHP shall certify to the Department, in writing, each monthly claim prior to submission to the State for reimbursement. The certification shall attest to the following for each beneficiary with services included in the claim:

(1) An assessment of the beneficiary was conducted in compliance with the requirements established in the MHP contract with the Department.

(2) The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.

(3) The services included in the claim were actually provided to the beneficiary.

(4) Medical necessity was established for the beneficiary as defined under this chapter for the service or services provided, for the timeframe in which the services were provided.

(5) A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department.

(6) For each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the Department.

NOTE: Authority: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code. Reference: Sections 5718,5719,5724,5767,5776,5777,5778 and 14684, Welfare and Institutions Code; and 42 CFR Part 433, Section 433.51, Part 438, Sections 438.604, 438.606 and 438.608, and Part 455, Section 455.18. (Adopted 7-1-03)

Article 3. Specialty Mental Health Services Other than Psychiatric Inpatient Hospital Services.

1840.304. Crosswalk between Service Functions and HCPCS Codes.

(a) When a provider bills the MHP for psychiatrist, psychologist, or EPSDT Supplemental Specialty Mental Health Services using a CPT or other HCPCS code in column A, then the MHP shall claim FFP based on the service function in column B at the units of time listed in column C. The dollar amount claimed shall be in accordance with Section 1840.105.

NOTE: Table deleted. See MHP contract, Exhibit A, Attachment I, Section __ for current reference.

(b) When a provider that is a hospital outpatient department bills the MHP for facility room use using the HCPCS codes 27500 or 27502 in addition to the CPT or other HCPCS code applicable to the specialty mental health service provided to the beneficiary, the MHP shall claim FFP for the combined codes under the applicable CPT or other HCPCS codes listed on the table in subsection (a). When a provider bills the MHP using a CPT or other HCPCS code that is not included on the table in section (a) other than 27500 or 27502, the MHP shall determine the appropriate service function for the service provided and shall claim FFP in accordance with Section 1840.308.

(c) An MHP may define a HCPCS code differently than defined in this subchapter in a contract between the MHP and a provider, provided the definition in the contract is not substantially different from the definition in this subchapter. Requiring that a provider other than a physician use a CPT code to bill for a therapy service shall not be considered to be substantially different.

(d) The lockouts described in Section 1840.215 and Sections 1840.360 through 1840.374 shall apply to claiming of FFP for services claimed under this section. For the purpose of determining lockouts the service shall be considered to be the service identified in column B at the units of time listed in column C.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1840.318. Claiming for Service Functions Based on Half Days or Full Days of Time.

(a) Day treatment intensive and day rehabilitation shall be billed as half days or full days of service.

(b) The following requirements apply for claiming of services based on half days or full days of time:

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

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

NOTE: Authority: Section 14680, Welfare and institutions Code.
Reference: Section.5778, Welfare and Institutions Code.

1840.328. Day Treatment Intensive Services Contact and Site Requirements.

Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1840.330. Day Rehabilitation Services Contact and Site Requirements.

Day Rehabilitation Services shall have a clearly established site for services, although all services need not be delivered at that site.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1840.350. Day Treatment Intensive Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight beneficiaries or other clients in attendance during the period the program is open.

(1) Physicians

(2) Psychologists or related waiveredhegistered professionals.

(3) Licensed Clinical Social Workers or related waivered/registered professionals.

(4) Marriage, Family and Child Counselors or related waiveredlregistered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons who are not solely used to provide Day Treatment Intensive services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

(c) Persons providing services in Day Treatment Intensive programs serving more than 12 clients shall include at least one person from each of two of the following groups:

(1) Physicians

(2) Psychologists or related waiveredhegistered professionals.

(3) Licensed Clinical Social Workers or related waiveredhegistered professionals.

(4) Marriage, Family and Child Counselors or related waiveredlregistered professionals,

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

1840.352. Day Rehabilitation Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Rehabilitation services to ten beneficiaries or other clients in attendance during the period the program is open.

(1) Physicians

(2) Psychologists or related waiveredhegistered professionals.

(3) Licensed Clinical Social Workers or related waiveredlregistered professionals.

(4) Marriage, Family and Child Counselors or related waiveredhegistered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons who are not solely used to provide Day Rehabilitation services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities.

(c) Persons providing services in Day Rehabilitation programs serving more than 12 clients shall include at least *two* of the following:

(1) Physicians

(2) Psychologists or related waiveredlregistered professionals.

(3) Licensed Clinical Social Workers or related waiveredlregistered professionals.

(4) Marriage, Family and Child Counselors or related waiveredhegistered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Mental Health Rehabilitation Specialists as defined in Section 630.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Section 5778, Welfare and Institutions Code.

Subchapter 5. Problem Resolution Processes

1850.205. Beneficiary Problem Resolution Processes.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a concern or complaint about any specialty mental health service-related issue.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A complaint resolution process.

(2) A grievance process.

(c) For both the complaint resolution process and the grievance process, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the complaint resolution process and the grievance process in the MHP's beneficiary brochure and providing the beneficiary brochure to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining complaint resolution and grievance process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. For the purposes of this section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making grievance forms and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf.

(3) That a beneficiary's legal representative may use the complaint resolution process or the grievance process on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified as having responsibility for assisting a beneficiary with these processes at the beneficiary's request.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a complaint or grievance.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the complaint resolution or grievance process are transmitted to the MHPs Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for review and, if applicable, implementation of needed system changes.

(d) In addition to meeting the requirements of subsection (c), the complaint resolution process shall. at a minimum:

(1) Provide for resolution of a beneficiary's concerns or complaints as quickly and simply as possible.

(2) Involve simple, informal and easily understood procedures that do not require beneficiaries to present their concerns or complaints in writing.

(3) Inform a beneficiary of his or her right to use the grievance process or request a fair hearing at any time before, during or after the complaint resolution process has begun.

(4) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(e) In addition to meeting the requirements of subsection (c), the grievance process shall, at a minimum:

(1) Require that beneficiaries provide their concerns or complaints to the MHP as a written grievance.

(2) Provide for two levels of review within the MHP

(3) Provide for a decision on the grievance at each level of review within 30 calendar days of receipt of the grievance by that level of review within the MHP.

(4) Provide for an expedited review of grievances where the beneficiary is grieving a decision by a provider or the MHP to discontinue adult residential or crisis residential services. When the written grievance is received by the MHP prior to the beneficiary's discharge from the services, the beneficiary shall continue to receive the adult residential or crisis stabilization services and the MHP shall continue payment for the services until the MHP. responds to the grievance at the first level of review, at which point action may be taken by the provider or the MHP as appropriate based on the grievance decision. Services shall not be continued if the provider or the MHP determines that ongoing placement of the beneficiary in that facility poses a danger to the beneficiary or others.

(5) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(6) Provide for:

(A) Recording the grievance in a grievance log within one working day of the date of receipt of the grievance. The log entry shall include but not be limited to:

1. The name of the beneficiary.

2. The date of receipt of the grievance.

3. The nature of the problem.

(B) Recording the final disposition of a grievance, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

(C) An MHP staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance.

(D) Notifying the beneficiary or the appropriate representative in writing of the grievance decision and documenting the notification or efforts to notify the beneficiary, if he or she could not be contacted. When the notice contains the decision of the MHP's first level of review, the notice shall include the beneficiary's right to appeal to the second level of review and to request a fair hearing if the beneficiary disagrees with the decision instead of, before, during or after filing the grievance at the second level of review. When the notice contains the decision of the MHP's second level of review, the notice shall include the beneficiary's right to request a fair hearing if the beneficiary disagrees with the decision.

(E) If any providers were cited by the beneficiary or otherwise involved in the grievance, notifying those providers of the final disposition of the beneficiary's grievance.

(f) An MHP's grievance log and any other grievance process files, and any complaint resolution process files shall be open to review by the department, the State Department of Health Services, and any appropriate oversight agency.

(g) Nothing in this section precludes a provider other than the MHP from establishing complaint or grievance processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

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

(2) The provider's beneficiary problem resolution process fully complies with this section.

(3) No beneficiary is prevented from accessing the grievance process solely on the grounds that the grievance was incorrectly filed with either the MHP or the provider.

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

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5520 and 14684, Welfare and Institutions Code.

1850.210. Fair Hearing and Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP acts to deny an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with this subsection. Notice in response to a request for continuation of a specialty mental health service shall be provided in accordance with Title *22,* Section 51014.1. The Notice of Action under this subsection shall not be required in the following situations:

(1) The denial is a denial of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.'

(2) The denial is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the MHP.

(b) The MHP of the beneficiary shall provide the beneficiary with a Notice of Action when the MHP defers action on an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. The Notice of Action shall be delayed for 30 calendar days to allow the provider of the specialty mental health service time to submit the additional information requested by the MHP and to allow time for the MHP to make a decision. If, after 30 calendar days from the MHP's receipt of the MHP payment authorization request, the provider has not complied with the MHP's request for additional information, the MHP shall provide the beneficiary a notice of action to deny the service pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the MHP shall take appropriate action on the MHP payment authorization request as supplemented by the additional information, including providing a Notice of Action to the beneficiary if the service is denied or modified or if the MHP defers action on the MHP payment authorization request for an additional period of time. The Notice of Action under this subsection shall not be required when the MHP defers action on an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(c) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP modifies an MHP payment authorization request from a provider for a specialty mental health

service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action pursuant to this subsection shall not be required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services. The Notice of Action under this subsection shall not be required when the MHP modifies an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(d) The written Notice of Action issued pursuant to subsections (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the MHP.

(2) The reason for the action taken.

(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.

(4) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.

(D) The time limits for requesting fair hearing.

(e) The fair hearings under this section shall be administered by the State Department of Health Services.

(f) For the purpose of this'section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.1, shall mean the MHP.

(g) For the purposes of this section, "medical service" as cited in Title 22, Section 51014.1, shall mean those specialty mental health services that are subject to prior authorization by an MHP pursuant to subchapters 2 and 3.

(h) The provisions of this section do not apply to the decisions of providers including the MHP serving beneficiaries when prior authorization of the service by the MHP's authorization procedures is not a condition of payment to the provider for the specialty mental health service.

(i) When a Notice of Action would not be required under subsections (a), (b), or (c), the MHP of the beneficiary shall provide a beneficiary with Notice of Action under this subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The Notice of Action under this subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with subsection (d) and shall specify:

(1) The reason the medical necessity criteria was not met.

(2) The beneficiary's options for obtaining care outside the MHP, if applicable.

(3) The beneficiary's right to request a second opinion on the determination.

(4) The beneficiary's right to file a complaint or grievance with the MHP.

(5) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limits for requesting fair hearing.

NOTE: Authority cited: Section 14684, Welfare and Institutions Code.
Reference: Section 14684, Welfare and Institutions Code.

1850.215. Medical Assistance for Beneficiary Pending Fair Hearing Decision.

A beneficiary receiving specialty mental health services pursuant to this chapter shall have a right to file for continuation of specialty mental health services pending fair hearing pursuant to Title 22, Section 51014.2. For the purpose *of* this section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.2, shall mean the MHP. The time limits for filing for a

continuation of services pursuant to Title 22, Section 51014.2 shall not be extended by a beneficiary's decision to pursue an MHP's beneficiary problem resolution process as described in Section 1850.205.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 14684, Welfare and Institutions Code.

1850.305 Provider Problem Resolution and Appeal Processes.

(a) An MHP shall develop provider problem resolution and appeal processes that enable providers to resolve MHP payment authorization issues or other complaints and concerns.

(b) The MHP shall ensure that participating providers are provided written information regarding the provider problem resolution and appeal processes.

(c) The Provider Problem Resolution Process shall include, at a minimum:

(1) A means to identify and resolve provider concerns and problems quickly and easily.

(2) Utilize simple, informal, and easily understood procedures.

(3) Inform providers of their right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP.

(d) The Provider Appeal Process shall include the following:

(1) **A** provider may appeal a denied or modified request for MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to the MHP within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the time frames required by Sections 1820.220 or 1830.250, or established by the MHP pursuant to Section 1830.215.

(2) The MHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

(A) If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

(B) If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the department pursuant to subsection (e).

(C) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

(D) If applicable, the MHP shall have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the TAR to the fiscal intermediary for processing.

(3) If an MHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied by the MHP. If applicable under subsection (e), the provider may appeal directly to the department.

(e) When an appeal concerning the denial or modification of an MHP payment authorization request for the specialty mental health services provided in an emergency as described in Sections 1820.225, 1830.230, and 1830.245 is denied in full or in part by the MHP's Provider Appeal Process on the basis that the provider did not comply with the required timelines for notification or submission of the MHP payment request or that the medical necessity criteria were not met, the provider may appeal the denial or modification to the department.

(1) Hospitals and the individual, group or organizational providers who have provided specialty mental health services under Sections 1820.225, 1830.230, and 1830.245 to a beneficiary during the psychiatric inpatient hospital stay that is the subject of the appeal may appeal separately to the department unless they have agreed to another arrangement as a term of their contract with the MHP.

(2) If a provider chooses to appeal to the department an MHP's denial of MHP payment authorization, the appeal shall be submitted in writing, along with supporting documentation, within 30 calendar days from the date of the MHP's written decision of denial. The provider may appeal to the department within 30 calendar days after 60 calendar days from submission to the MHP, if the MHP fails to respond. Supporting documentation shall include, but not be limited to:

(A) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

(B) Clinical records supporting the existence of medical necessity if at issue.

(C) A summary of reasons why the MHP should have approved the MHP payment authorization.

(D) A contact person(s) name, address and phone number.

(3) The department shall notify the MHP and the provider of its receipt of a request for appeal pursuant to subsection (d) within seven calendar days. The notice to the MHP shall include a request to the MHP for specific documentation supporting denial of the MHP payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal pursuant to subsection (d)(1).

(4) The MHP shall submit the requested documentation within 21 calendar days or the department shall decide the appeal based solely on the documentation filed by the provider.

(5) The department shall have 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation, whichever is earlier, to notify the provider and the MHP, in writing, of its decision, including a statement of the reasons for the decision that addresses each issue raised by the provider and the MHP, and any actions required by the MHP or the provider to implement the decision. At the election of the provider, if the department fails to act within the 60 calendar days, the appeal may be considered to have been denied by the department.

(A) The department may allow both a provider representative(s) and the MHP representative(s) an opportunity to present oral argument to the department.

(B) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the department's decision to uphold the appeal.

(C) If applicable, the MHP shall have 14 calendar days from the receipt of the provider's revised MHP payment authorization request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Section 14684, Welfare and Institutions Code.

1850.405. Resolution of Disputes between MHPs regarding MHP of Beneficiary.

(a) Under the following arbitration processes'the MHP of the beneficiary may be determined to be different than that specified in the Medi-Cat Eligibility Data System (MEDS) file.

(b) Any two or more MHPs may develop an arbitration agreement to provide for determining final responsibility for MHP payment authorization as described in subchapters 2 and 3 when there is a dispute between the participating MHPs. Each arbitration agreement must:

(1) Provide for the selection of an arbitrator.

(2) Include timelines for filing and resolution.

(3) Include criteria that will serve as a basis for a decision.

(4) Specify that decisions reached under the arbitration process will be final.

(5) Be signed by all participating MHPs or their designees.

(6) Require that all decisions of the arbitrator shall be in writing.

(7) Provide that a copy of each decision shall be forwarded to the affected MHPs within 14 calendar days of the decision.

(c) In cases where there is a disagreement between MHPs that are not participating in an arbitration process, the arbitration process shall be as follows:

(1) Each MHP shall provide the department with at least one individual available to serve as an arbitrator. The MHP shall confirm or update the available individuals annually. The department shall provide a listing of the available individuals to the MHPs annually by October 1. The parties to the dispute may agree to a single arbitrator. If the parties to the dispute cannot agree on a single arbitrator, the parties shall each select an arbitrator from the list of available individuals, except that an individual identified by either involved MHP may not be selected. The selected arbitrators shall select a third arbitrator who is not an individual identified by either involved MHP from the listing.

(2) The arbitrators' services shall be reimbursed at the hourly rate charge by the State Office of Administrative Hearings for hearings it conducts for other state agencies, not to' exceed a total of ten hours. The parties shall share equally in paying for the arbitrators' services. Payment shall be made directly to the arbitrators unless the arbitrator is an employee of the MHP, in which case payment shall be made to that MHP.

(3) The arbitrators' decision as to the MHP of the beneficiary shall be based on a review of the facts in relation to the following criteria:

(A) If a beneficiary has moved to a county OF acts to establish residency in a county and has a clear intent to reside in the county, the MHP for that county shall be considered the MHP of the beneficiary.

(B) If a beneficiary is a Lanterman-Petris-Short or Probate Conservatee, the MHP for the county in which the beneficiary is conserved shall be considered the MHP of the beneficiary.

(C) If a beneficiary has been placed in legal custody by a county, the MHP for the county that initiated the legal proceeding shall be considered the MHP of the beneficiary. If a beneficiary is on parole or in a conditional release program and is restricted to a particular area,

the MHP for the county which includes the area to which the beneficiary is restricted shall be the MHP of the beneficiary.

(D) If a beneficiary has adopted a transient, nomadic lifestyle and has a clear intent to continue this lifestyle, the MHP for the county in which the beneficiary presents for services shall be considered the MHP of the beneficiary.

(E) If a beneficiary, because of the beneficiary's mental status, is unable to form or express a clear intent to reside anywhere, the following may be considered evidence that the MHP for the county involved would be the MHP of the beneficiary:

1. The county that originated residential, medical, or psychiatric placement.

2. The county in which the beneficiary has current housing.

3. The county that has paid general assistance to the beneficiary.

4. The county in which the beneficiary has received ongoing community mental health clinical care during the last six months.

(F) Where the facts do not clearly meet the criteria, the arbitrators' decision shall be reasonable in light of the facts presented using the criteria in **(A)** through (E)' as a general guidelines.

(4) The affected MHPs shall provide relevant documentation to arbitrators no later than 21 calendar days after the arbitrators have been selected.

(5) The arbitrators shall decide on the issue no later 60 calendar days

(A) from the date documentation is received from the affected MHPs, or

(B) from 21 calendar days after the arbitrator has been selected, whichever is sooner.

(6) The arbitrators shall issue the decision in writing to the affected MHPs within **14** calendar days of the decision.

(d) When the arbitrators acting under either subsections (b) or (c) determine that an MHP is responsible for payment for specialty mental health services previously authorized by another **MHP,** the MHP found responsible for payment of services shall perform, within 14 calendar days from the date of the arbitrator's decision, any action required of the MHP to implement the decision of the arbitration process. The department reserves the right to take action necessary to implement the decision of the arbitration process if the MHP found to be responsible fails to comply with the decision.

(e) A dispute regarding the MHP of the beneficiary shall not delay medically necessary services to beneficiaries. The MHP of the beneficiary as identified on the MEDS file shall be responsible for providing or authorizing and paying for the service until the dispute is resolved.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code

FEDERAL REGULATONS CROSS-REFERENCED IN CONTRACT 0501

Various Parts related to PART 438—MANAGED CARE

Sec. 422.128 Information on Advance Directives

(a) Each M+C organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, advance directive has the meaning given the term in Sec. 489.100 of this chapter.
(b) An M+C organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the M+C organization.
(1) An M+C organization must provide written information to those individuals with respect to the following:
(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.
(ii) The M+C organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the M+C organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:
(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.
(B) Identify the state legal authority permitting such objection.
(C) Describe the range of medical conditions or procedures affected by the conscience objection.
(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the M+C organization may give advance directive information to the enrollee's family or surrogate in the same manner. that it issues other materials about policies and procedures to the family of the incapacitated enrollee or *to* a surrogate or other concerned persons in accordance with State law. The M+C organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.
(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.
(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.
(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.
(H) Provide for education of staff concerning its policies and procedures on advance directives.

(I) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the M+C organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An M+C organization must be able to document its community education efforts. 0502

(2) The M+C organization--

(i) Is not required to provide care that conflicts with an advance directive; and

(ii) Is not required to implement an advance directive if, as a matter of conscience, the M+C organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.

(3) The M+C organization must inform individuals that complaints concerning noncompliance. with the advance directive requirements may be filed with the State survey and certification agency.

Sec. 489.100 Definition.

For purposes of this part, advance directive 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 health care when the individual is incapacitated.

Sec. 431.244 Hearing decisions.

. . . .

(f) The agency must take final administrative action as follows:

(1) Ordinarily, within 90 days from the earlier of the following:

(i) The date the enrollee filed an MCO or PIHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing; or

(ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing.

(2) As expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP, the case file and information for any appeal of a denial of a service that, as indicated by the MCO or PIHP—

(i) Meets the criteria for expedited resolution as set forth in Sec. 438.410(a) of this chapter, but was not resolved within the timeframe for expedited resolution; or

(ii) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the enrollee.

(3) If the State agency permits direct access to a State fair hearing; as expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, directly from an MCO or PIHP enrollee, a fair hearing request on a decision to deny a service that it determines meets the criteria for expedited resolution, as set forth in Sec. 438.410(a) of this chapter. . . .

PART 438—MANAGED CARE
Subpart A—General Provisions

Sec. 438.6 Contract requirements.

(a) Regional office review. The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in Sec. 438.806.
(b) Entities eligible for comprehensive risk contracts. (N/A)
(c) Payments under risk contracts. (NIA)
(d) Enrollment discrimination prohibited. (NIA)
(f) Compliance with contracting rules. All contracts under this subpart must:
(1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; and
(2) Meet all the requirements of this section.
(g) inspection and audit of financial records. Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.
(h) Physician incentive plans.
(1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in Secs. 422.208 and 422.210 of this chapter.
(2) In applying the provisions of Secs. 422.208 and 422.210 of this chapter, references to ``M+C organization'', ''CMS'', and ''Medicare beneficiaries'' must be read as references to ''MCO, PIHP, or PAHP'', ''State agency'' and ''Medicaid recipients'', respectively.
(i) Advance directives.
(1) All MCO and PIHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives.
(2) All PAHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in Sec. 489.102(a) of this chapter.
(3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.
(4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.
(j) Special rules for certain HIOs. (N/A)
(k) Additional rules for contracts with PCCMs. (N/A)
(l) Subcontracts. All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.
(m) Choice of health professional. The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

Sec. 438.10 Information requirements.
(a) Terminology. As used in this section, the following terms have the indicated meanings:
Enrollee means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.
Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.
(b) Basic rules.

(1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. 0504
(2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.
(3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.
(c) Language. The State must do the following:
(1) Establish a methodology for identifying the prevalent non- English languages spoken by enrollees and potential enrollees throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.
(2) Make available written information in each prevalent non- English language.
(3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.
(4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.
(5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—
(i) That oral interpretation is available for any language and written information is available in prevalent languages; and
(ii) How to access those services.
(d) Format. (1) Written material must—
(i) Use easily understood language and format; and
(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
(2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
(e) Information for potential enrollees.
(1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:
(i) **At** the time the potential enrollee first becomes eligible to enroll in a voluntary program, or **is** first required to enroll in a mandatory enrollment program.
(ii) Within a timeframethat enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHPs, or PCCMs.
(2) The information for potential enrollees must include the following:
(i) General information about—
(A) The basic features of managed care;
(B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and
(C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;
(ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
(A) Benefits covered.
(B) Cost sharing, if any.
(C) Service area.

(D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals. 0505

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.

(f) General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs. Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:

(1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.

(2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.

(3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment.

(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.

(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees:

(i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.

(ii) Any restrictions on the enrollee's freedom of choice among network providers.

(iii) Enrollee rights and protections, as specified in Sec. 438.100.

(iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in Sec. 438.10(g)(1), and for PAHP enrollees, the information specified in Sec. 438.10(h).

(v) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.

(vi) Procedures for obtaining benefits, including authorization requirements.

(vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

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

(A) What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in Sec. 438.114(a).

(B) The fact that prior authorization is not required for emergency services.
(C) The process and procedures for obtaining emergency services, including use of the 911- 0506
telephone system or its local equivalent.
(D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract.
(E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.
(ix) The poststabilization care services rules set forth at Sec. 422.113(c) of this chapter.
(x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
(xi) Cost sharing, if any.
(xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.
(g) Specific information requirements for enrollees of MCOs and PIHPs. In addition to the requirements in Sec. 438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees:
(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in Secs. 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:
(i) For State fair hearing—
(A) The right to hearing:
(B) The method for obtaining a hearing; and
(C) The rules that govern representation at the hearing.
(ii) The right to file grievances and appeals.
(iii) The requirements and timeframes for filing a grievance or appeal.
(iv) The availability of assistance in the filing process.
(v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
(vi) The fact that, when requested by the enrollee—
(A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and
(B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
(vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
(2) Advance directives, as set forth in Sec. 438.6(i)(2).
(3) Additional information that is available upon request, including the following:
(i) Information on the structure and operation of the MCO or PIHP.
(ii) Physician incentive plans as set forth in Sec. 438.6(h) of this chapter.
(h) Specific information for PAHPs. . ...
(i) Special rules: States with mandatory enrollment under State plan authority—. . .

Subpart C--Enrollee Rights and Protections

Sec. 438.100 Enrollee rights.
(a) General rule. The State must ensure that—

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(1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and
(2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.
(b) Specific rights—
(1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.
(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to –
(i) Receive information in accordance with Sec. 438.10.
(ii) Be treated with respect and with due consideration for his or her dignity and privacy.
(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in Sec. 438.10(f)(6)(xiii).)
(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.
(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and **E,** applies, request and receive a copy *of* his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Sec. 164.524 and 164.526.
(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with Secs. 438.206 through 438.210.
(c) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.
(d) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act *of* 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

Subpart D--Quality Assessment and Performance Improvement

Sec. 438.204 Elements *of* State quality strategies.
At a minimum, State strategies must include the following:
(a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.
(b) Procedures that—
(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
(2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
(3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.
(d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
(e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
(f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

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Sec. 438.240 Quality assessment and performance improvement program.
(a) General rules.
(1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.
(2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.
(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:
(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
(2) Submit performance measurement data as described in paragraph (c) of this section.
(3) Have in effect mechanisms to detect both underutilization and overutilization of services.
(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
(c) Performance measurement. Annually each MCO and PIHP must—
(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of Sec. 438.204(c) and Sec. 438.240(a)(2);
(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance: or
(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.
(d) Performance improvement projects.
(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. and that involve the following:
(i) Measurement of performance using objective quality indicators.
(ii) Implementation of system interventions to achieve improvement in quality.
(iii) Evaluation of the effectiveness of the interventions.
(iv) Planning and initiation of activities for increasing or sustaining improvement.
(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of Sec. 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to

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generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
(e) Program review by the State.
(1) The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include—
(i) The MCO's and PIHP's performance on the standard measures on which it is required to report; and
(ii) The results of each MCO's and PIHP's performance improvement projects.
(2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

Subpart F--Grievance System
(Please note that not all provisions apply to Mental Health Plans per approved waiver renewal request. See contract terms to identify specific requirements of the MHPs.)

Sec. 438.400 Statutory basis and definitions.
(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.
(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
Action means-- In the case of an MCO or PIHP—
(1) The denial or limited authorization of a requested service,, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure to provide services in a timely manner, as defined by the State;
(5) The failure of an MCO or PIHP to act within the timeframes provided in Sec. 438.408(b); or
(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under Sec. 438.52(b)(2)(ii), to obtain services outside the network.
Appeal means a request for review of an action, as "action" is defined in this section.
Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances 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 enrollee's rights.)

Sec. 438.402 General requirements.
(a) The grievance system. Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.
(b) Filing requirements—
(1) Authority to file.—

(i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.
(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.
(2) Timing. The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—
(i) The enrollee or the provider may file an appeal; and
(ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.
(3) Procedures.
(i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.
(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

Sec. 438.404 Notice *of* action.
(a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.
(b) Content of notice. The notice must explain the following:
(1) The action the MCO or PIHP or its contractor has taken or intends to take.
(2) The reasons for the action.
(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
(5) The procedures for exercising the rights specified in this paragraph.
(6) The circumstances under which expedited resolution is available and how to request it.
(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
(c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:
(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in Secs. 431.211, 431.213, and 431.214 of this chapter.
(2) For denial of payment, at the time of any action affecting the claim.
(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in Sec. 438.210(d)(1).
(4) If the MCO or PIHP extends the timeframe in accordance with Sec. 438.210(d)(1), it must—
(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
(5) For service authorization decisions not reached within the timeframes specified in Sec. 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
(6) For expedited service authorization decisions, within the timeframes specified in Sec. 438.210(d).

Sec. 438.406 Handling of grievances and appeals.

(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:

(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(2) Acknowledge receipt of each grievance and appeal.

(3) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were not involved in any previous level of review or decision-making; and

(ii) Who, *if* deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file,. including medical records, and any other documents and records considered during the appeals process.

(4) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

Sec. 438.408 Resolution and notification: Grievances and appeals.

(a) Basic rule. The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) Specific timeframes.—

(1) Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.

(2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) Expedited resolution of appeals. For expedited resolution ,of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the **MCO** or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) Extension of timeframes.—

(1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) Requirements following extension. If the MCO or PIHP extends the timeframes, it must–for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay. 0512

(d) Format of notice.—

(1) Grievances. The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.

(2) Appeals.

(i) For all appeals, the MCO or PIHP must provide written notice *of* disposition.

(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.

(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so;

(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and

(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's 'action.

(f) Requirements for State fair hearings.—

(1) Availability. The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies—

(i) If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or

(ii) If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.

(2) Parties. The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Sec. 438.410 Expedited resolution of appeals.

(a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) Punitive action. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) Action following denial of a request for expedited resolution. If the **MCO** or PIHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with Sec. 438.408(b)(2);

(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

Sec. 438.414 Information about the grievance system to providers and subcontractors.

The MCO or PIHP must provide the information specified at Sec. 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

Sec. 438.416 Recordkeeping and reporting requirements.
The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy. 0513

Sec. 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.
(a) Terminology. As used in this section, "*timely" filing* means filing on or before the later of the following:
(1) Within ten days of the MCO or PIHP mailing the notice of action.
(2) The intended effective date of the MCO's or PIHP's proposed action.
(b) Continuation of benefits. The MCO or PIHP must continue the enrollee's benefits if—
(1) The enrollee or the provider files the appeal timely;
(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
(3) The services were ordered by an authorized provider;
(4) The original period covered by the original authorization has not expired; and
(5) The enrollee requests extension of benefits.
(c) Duration of continued or reinstated benefits. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
(1) The enrollee withdraws the appeal.
(2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.
(4) The time period or service limits of a previously authorized service has been met.
(d) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in Sec. 431.230(**b**) of this chapter.

Sec. 438.424 Effectuation of reversed appeal resolutions.
(a) Services not furnished while the appeal is pending. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
(b) Services furnished while the appeal is pending. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

Subpart H--Certifications and Program Integrity

Sec. 438.604 Data that must be certified.
(a) Data certifications. When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in Sec. 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required **by** the State and contained in contracts, proposals, and related documents.

(b) Additional certifications. Certification is required, as provided in Sec. 438.606, for all documents specified by the State.

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Sec. 438.606 Source, content, and timing of certification.
[a) Source of certification. For the data specified in Sec. 438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:
(1) The MCO's or PIHP's Chief Executive Officer.
(2) The MCO's or PIHP's Chief Financial Officer.
(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.
(b) Content of certification. The certification must attest, based on best knowledge, information, and belief, as follows:
(1) To the accuracy, completeness and truthfulness of the data.
(2) To the accuracy, completeness and truthfulness of the documents specified by the State.
(c) Timing of certification. The MCO or PIHP must submit the certification concurrently with the certified data.

Sec. 438.610 Prohibited Affiliations with Individuals Debarred by Federal Agencies.
(a) General requirement. An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:
(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.
(b) Specific requirements. The relationships described in this paragraph are as follow:
(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP.
(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity.
(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.
(c) Effect of Noncompliance. If a State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance with paragraphs (a) and (b) of this section, the State:
(1) Must notify the Secretary of the noncompliance.
(2) May continue an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary directs otherwise.
(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary provides *to* the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.
(d) Consultation with the Inspector General. Any action by the Secretary described in paragraphs (c)(2) or (c)(3) of this section is taken in consultation with the Inspector General.

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COUNTY OF SANTA CRUZ
REQUEST FOR APPROVAL OF AGREEMENT

TO. Board of Supervisors
County Administrative Office
Auditor Controller

FROM: **Health Services Agency** ,(Degartment)

BY: _____ (Signature) 5/19/4 (Date)

Signature certifies that appropriations/revenues are available

AGREEMENT TYPE (Check One) Expenditure Agreement ☐ Revenue Agreement ☐

The Board of Supervisors is hereby requested to approve the attached agreement and authorize the execution of same.

1. Said agreement is between the **Health Services Agency - Mental Health** (Department/Agency)

and **State Dept of Mental Health, 1600 9th St, Sacramento, CA 95814** (NamelAddress)

2. The agreement will provide **state mental health hospital beds**

State Contract 03-73248-000

3. Period of the agreement is from **July 1, 2003** to **June 30.2004**

4. Anticipated Cost Is $ **265,969** ☐ Fixed ☐ Monthly Rate ☐ Annual Rate ☐ Not to Exceed

Remarks: **Auditor - DO NOT ENCUMBER THIS AGREEMENT - payment is offset from Realignment payments**

5. Detail: ☐ On Continuing Agreements List for FY - Page CC- _____ Contract, NO: 30336 OR ☒ 1st Time Agreement

☐ Section II No Board letter required, will be listed under Item 8
☒ Section III Board letter required
☐ Section IV Revenue Agreement

6. Appropriations/Revenues are available and are budgeted in **363149** (Index) **6102** (Sub object)

NOTE: IF APPROPRIATIONS ARE INSUFFICIENT, ATTACHED COMPLETED AUD-74 OR AUD-60

Appropriations ~~are~~ are not ~~available and~~ have been ~~will be~~ ~~encumbered.~~

N/A N/A

Contract No: 30336

By: _____ Auditor/Controller Deputy Date: 6/3/04

Proposal and accounting detail reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize

Health Services Agency Director (Dept/Agency Head) to execute on behalf of the

Health Services Agency (Department/Agency)

Date: _____ By: _____ County Administrative Office

Distribution:
Board of Supervisors - White
Auditor Controller - Canary
Auditor-Controller - Pink
Department - Gold

ADM - 29 (8101)
Title I, Section 300 Proc Man

State of California
County of Santa Cruz
I Susan A. Mauriello ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz, State of California, do hereby certify that the foregoing request for approval of agreement was approved by said Board of Supervisors as recommended by the County Administrative Office by an order duly entered in the minutes of said Board on June 15 2004

By: Sharon Mitchell Deputy Clerk

AUDITOR-CONTROLLER USE ONLY

CO_____ $_____ _____

Document No. JE Amount Lines H/TL Keyed By Date

TC110_____ $_____ I

Auditor Description Amount Index Sub object User Code

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STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213 (Rev 09/01)

CONTRACTOR COPY

AGREEMENT NUMBER
03-73248-000

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

STATE AGENCY'S NAME
Department of Mental Health .

CONTRACTOR'S NAME
Santa Cruz County Mental Health and Substance Abuse Services

2. The term of this Agreement is: **July 01,2003 through June 30,2004**

3. The maximum amount of this Agreement is: **$0.00** **No Dollars and No Cents**

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

Exhibit A – Scope of Work	16 pages
Exhibit B – Budget Detail and Payment Provisions	3 pages
Exhibit C – General Terms and Conditions (Exhibit C is not applicable to this Agreement)	0 pages
Exhibit D - Special Terms and Conditions	3 pages
Exhibit E – Additional Provisions	2 pages

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

CONTRACTOR

CONTRACTORS NAME *(if other than an individual, state whether a corporation, partnership. etc.)*
Santa Cruz County Mental Health and Substance Abuse Services

BY *(Authorized Signature)*
DATE SIGNED *(Do not type)* 6-15-04

PRINTED NAME AND TITLE OF PERSON SIGNING
RAMA KHALSA HSA DIRECTOR

ADDRESS
~~320 Encinal Street~~ 1080 EMELINE AVE
Santa Cruz, CA 95060

STATE OF CALIFORNIA

AGENCY NAME
Department of Mental Health

BY *(Authorized Signature)*
DATE SIGNED *(Do not type)* 6/30/04

PRINTED NAME AND TITLE OF PERSON SIGNING
Acting Contracting & Procurement Officer
Administrative Services

ADDRESS
1600 9th Street
Sacramento, CA 95814

California Department of General Services Use Only

Exempt for Compliance with the Public Contract Code, the State Administrative Manual, and from approval by the Department of General Services per Section 4331(a) of the Welfare and Institutions Code

FULLY EXECUTED

APPROVED
JUN 30 2004
THIS CONTRACT HAS BEEN FULLY APPROVED BY THE STATE OF CALIFORNIA

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EXHIBIT A
STATE HOSPITAL BED PURCHASE AND USAGE

SCOPE OF WORK

1. PURPOSE AND DESCRIPTION OF SERVICES

A. Facilities, Payments and Services

Section 4330 of the California Welfare and Institutions Code (WIC) requires counties to reimburse the State Department of Mental Health, hereafter referred to as the "DMH" or "Department," for use of state hospital beds/services provided pursuant to Part 1 (commencing with Section 5000) of Division 5 of the WIC. The County shall compensate the DMH and the DMH agrees to provide the services, including staffing, facilities, equipment and supplies in accordance with the provisions of Exhibit B of this Standard Agreement, hereafter referred to as the "Agreement."

The DMH has jurisdiction over Atascadero, Metropolitan, Napa and Patton State Hospitals, which provide services to persons with mental disorders, in accordance with the WIC Section 4100 et seq. The DMH shall operate the hospitals continuously throughout the term, as indicated under Exhibit D, I (Term), with at least the minimum number and type of staff which meet applicable state and federal regulations and which are necessary for the provisions of the services hereunder. County reimbursements shall be made in accordance with Exhibit B of this Agreement.

B. County Responsibility

I. The County may review the quantity and quality of services provided pursuant to this Agreement, including the following:

a. Medical and other records of county patients. **A** copy of the review report, if any, shall be provided to the hospitals.

b. Hospital procedures for utilization review and quality assurance **(QA)** activities and related committee minutes and records, except for privileged communications and documents.

c. Periodic meetings regarding the quantity and quality of services are encouraged with the hospital Medical Director, or designee.

2. The County shall screen, determine the appropriateness of, and authorize all referrals for admission of county patients to the hospitals. The County shall, at the time of admission, provide admission ,authorization, identify the program to which a patient is being referred, and identify the estimated length of stay for each county patient. However, the hospital Medical Director or designee shall make the

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determination of the appropriateness of a county referred patient for admission to a hospital and assign the patient to the appropriate level of care and treatment unit.

3. The County shall provide such assistance as is necessary to assist the hospital treatment staff to initiate, develop and finalize discharge planning and necessary follow-up services.

4. The County shall provide such assistance as is necessary to assist in the screening of county patients for alternative placements, and shall facilitate such placements.

5. The County shall provide case management services, as defined in H (Coordination of Treatment/Case Management) of Exhibit A.

C. Description of Covered Hospital Services

1. The DMH shall provide Lanterman-Petris-Short (LPS) hospital services only to those persons referred by the County specifically for services under this Agreement, including those admitted pursuant to Sections 1370.01 of the Penal Code (PC) and Murphy Conservatorship (Section 5008(h)(1)(B) of the WIC). When patients, committed pursuant to provisions of the PC are converted to LPS billing status they shall become the financial responsibility of the county of first admission and part of that county's LPS dedicated bed capacity as described in F (Admission and Discharge Procedures) of Exhibit **A.**

   Former inmates of the California Department of Corrections (CDC) who convert to Murphy Conservatees following concurrent Incompetent to Stand Trial (IST) commitments will, at the expiration of their CDC commitment, be the responsibility of the county that sent the inmate to prison.

   The County Mental Health Director, or designee, shall be involved in the conversion process and the conversion shall be made in accordance with the provisions of P (Notices), item 4 of Exhibit **A** and the provisions of Divisions 5 and 6 of WIC.

   The following services are provided:

   Psychiatric and Ancillary Services-

   The DMH shall provide inpatient psychiatric health care and support services, including appropriate care and treatment to county patients who suffer from mental, emotional or behavioral disorders and who have been referred to the hospitals by the County.

   The DMH shall not refuse to admit patients referred from the County when the County has a bed available within its dedicated capacity and the patient, in the judgment of the hospital Medical Director or designee, meets the established criteria for admission, and any other provisions contained in this Agreement.

The hospitals shall provide psychiatric treatment and other services in accordance with all applicable laws and regulations, including, but not limited to, Title 22 and Title **9** of the California Code of Regulations (CCR).

The hospitals shall provide all ancillary services necessary for the evaluation and treatment *of* psychiatric conditions. To the extent possible, medical procedures performed prior to a patient's admission to the hospital shall not be duplicated.

2. Expert Testimony

The DMH and the counties shall provide or cause to be provided expert witness testimony by appropriate mental health professionals in legal proceedings required for the institutionalization, admission, or treatment of county patients. These proceedings may include, but not be limited to, writs of habeas corpus, capacity hearings (Reise) as provided in Section 5332 et seq. of the WIC, conservatorship, probable cause hearings, court-ordered evaluation and appeal and post-certification proceedings.

3. Health Care Services

The DMH shall provide or cause to be provided any health care services, including physician or other professional services, required **by** county patients served pursuant to this Agreement. In cases where non-emergent or elective medical/surgical care is recommended by hospital medical staff and where the cost for such care is likely to exceed $5,000, the hospital Medical Director shall confer with the County's Medical Director, or designee, regarding the provision of service, including the option that, at the County's discretion, the County may make arrangements for the provision of such service.

4. Electro-ConvulsiveTherapy

The hospitals may cause to be provided Electro-Convulsive Therapy, herein referred to as "ECT," in accordance with applicable laws, regulations, and established state policy.

5. Transportation

Transportation to and from the hospitals, including court appearances, county-based medical appointments or services, and pre-placement visits and final placements, shall be the responsibility of the County. The County shall also be responsible for transportation between hospitals when the County initiates the transfer. Other transportation between state hospitals and transportation to and from local medical appointments or services shall be the responsibility of the hospitals.

D. Standards of Care

1. Staffing

a. The hospitals shall staff each hospital unit, which provides services under this Agreement in accordance with acceptable standards of clinical practice, applicable state staffing standards and any applicable court orders or consent decrees. The DMH shall provide administrative and clerical staff to support the staffing specified and the services provided hereunder.

b. The hospitals shall make a good faith effort to provide sufficient bilingual staff with experience in a multicultural community sufficient to meet the needs of patients treated pursuant to this Agreement.

2. Licensure

The hospitals shall comply with all applicable federal and state laws, licensing regulations and shall provide services in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment. The hospitals, which are accredited, shall make a good faith effort to remain accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) throughout the term of this Agreement.

3. Patient Rights

a. The hospitals shall in all respects comply with federal and state requirements regarding patient rights in .accordance with Sections 5325 and 5325.1 of the WIC and Sections 862 through 868 of Title **9** of the CCR. The hospitals shall include ECT reporting, as required by law, in its quarterly "Electro-Convulsive Therapy" report submitted to the DMH.

b. The hospitals shall follow established procedures for resolving patient complaints. Patient complaints relating to violations of their rights during their hospitalization shall be handled and resolved by the DMH Contract Advocate, Protection and Advocacy Incorporated. Patients rights issues pertaining to matters outside the jurisdiction of the hospitals, shall be the responsibility of the County's patients' rights advocate. Issues relating to the denial of patients' rights pursuant to Section 5325 of the WIC, shall be reported quarterly to the DMH, as required by law, on the DMH "Denial of Rights" form.

4. Informed Consent

The hospitals shall comply with applicable law relating to informed consent.

E. Planning

The County may participate in regional committees of the CMHDA Long Term Care Committee. Staff from the DMH Long Term Care Services Division and staff from the state hospitals used by regional members may meet with the regional committee at the chairpersons request to discuss program, staffing, and capacity changes. These types of issues may also be discussed between the DMH and the counties as part of the agenda of the CMHDA Long Term Care Committee and when appropriate with the CMHDA Executive Board.

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F. Admission and Discharge Procedures

1. Admission and Discharges Procedures

a. Admission Procedures

(1) The County shall be directly involved in referring county patients for admission to the hospitals, discharge planning, and the actual discharge process. When an individual committed pursuant to provisions of the PC is converted to an LPS commitment the County Mental Health Director, or designee, shall be involved as provided in this Agreement and in accordance with the provisions of Divisions 5 and 6 of the WIC.

(2) If the County is below dedicated capacity, it shall have immediate access to a bed for any county patient who is determined by the hospital Medical Director, or designee, to be clinically appropriate for the available bed/service. Admission shall be accomplished in accordance with hospital admitting procedures and admission hours. The hospitals shall make a good faith effort to flexibly accommodate patients referred for admission in a manner, which maximizes access to appropriate hospital beds and services.

(3) If the County is at or above its dedicated capacity, the County may arrange a bed exchange with another county, which is below its dedicated capacity. At the time of admission the hospital shall be provided written authorization from both the referring county and the county whose bed will be used.

(4) If, for any reason, a county patient is in a bed which is inappropriate to that patient's needs, the attending clinician shall develop, in consultation with the treatment team and the County, except when the urgency of the patient's situation precludes such consultation, a plan for transfer of the patient to an appropriate unit in accordance with the treatment plan.

(5) All denials of admission shall be in writing with an explanation for the denial. Denials shall not occur if the patient meets the admission criteria and the County has dedicated capacity available, or has obtained authorization from another county to use its available dedicated capacity. **A** denial of admission may be appealed as provided in F3a (Appeal Procedures-Admissions), found within this section.

2. Discharge Procedures

a. Discharge planning shall begin at admission.

b. The development of a discharge plan and the setting of an estimated discharge date shall be done jointly by the treatment team and the County's designated case manager. The treatment plan shall identify the discharge plan.

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c. **A** hospital shall discharge a patient at the County's request or in accordance with the approved discharge plan except: (1) if at the time the discharge is to occur, the hospital's Medical Director, or designee, determines that the patient's condition and the circumstances of the discharge would pose an imminent danger to the safety of the patient or others; or, (2) when a duly appointed conservator refuses to approve the patient's discharge or placement. A denial of discharge may be appealed as provided in F3b (Discharges), found within this section.

3. Appeal Procedures

a. Admissions

When agreement cannot be reached between the County's staff and the hospital admitting staff regarding whether a patient meets or does not meet the admission criteria for the bed(s) available the following appeal process shall be followed. When the County's staff feel that impasse has been reached and further discussions would not be productive, the, denial of admission may be appealed, along with all available data and analysis to the hospital Medical Director and the County Mental Health Director. Such appeals may be made immediately by telephone. If the hospital Medical Director and the County Mental Health Director are unable to achieve agreement, the case may be referred to the Deputy Director, Long Term Care Services within two (2) working days. The Deputy Director shall discuss the case with the County Mental Health Director and may obtain additional consultation. The Deputy Director shall render a final decision within two (2) working days after receiving the documented basis on which the appeal is based.

b. Discharges

When the hospital Medical Director, or designee, determines that discharge cannot occur in accordance with the approved plan or upon the request of the County, he/she will contact the County's Mental Health Director or designee immediately to review the case and will make every effort to resolve the issues preventing the discharge. If this process does not result in agreement, the case may be referred to the Deputy Director, Long Term Care Services, by the County Mental Health Director within one (1) working day of the hospital's denial. The Deputy Director after consultation with the County Mental Health Director and others will make the final decision within two (2) working days of receiving the documentation of the basis of the disagreement regarding discharge, and communicate this decision to the County Mental Health Director and the hospital Medical Director by telephone followed by written confirmation.

4. Penalties

a. Should the DMH fail to process appeals from the County relating to the denial of admissions or discharges within the timelines specified in the preceding F3a and F3b, the County shall be allowed to use additional bed days equal to the

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number of days lost due to the DMH's failure to respond within the established time lines. The penalty days thus provided shall be in the cost center to which the patient in question was referred.

b. If the decision on appeal shall be against the hospital, the County shall be allowed to use additional bed days equal to the number of days lost due to the hospital's failure to admit or discharge the patient in accordance with the County's request.

G. Prior Authorization

The County shall, prior to admission, provide the hospitals with a completed Short-Doyle Authorization Form (MH 1570) and all applicable court commitment orders. An initial projected length of stay shall be identified by the County and addressed in the patient's treatment plan and discharge plan.

H. Coordination of Treatment/Case Management

The parties agree that client services must be integrated and coordinated across levels of care, and that an active case management system is a critical factor in this continuity of care. Accordingly, the parties agree to the following case management system:

1. The County shall develop an operational case management system for county patients, and shall identify a case manager or case management team for each county patient. The duties of the case manager include, but are not limited to:

   a. Providing available assessment information on patients admitted to the hospitals.

   b. Participating in person or by telephone in an initial meeting with the patient and the hospital treatment team within a reasonable time frame after admission, for purposes of participating in the development of a treatment plan and a discharge plan, and to determine the level of the case manager's involvement during the patient's hospitalization. The treatment plan shall form the basis for the treatment and services provided to the county patient.

   c. Meeting, in person, with the county patient and with the hospital treatment team on a regular basis, not to exceed 180 days between meetings, to provide direct input into the development and implementation of the patient's treatment plan.

   d. Ensuring that appropriate alternative placement options are developed as a part of the discharge planning process, and working closely with the hospital treatment teams to assure that discharges take place when and in a manner agreed upon by the hospital Medical Director or designee, and the County Mental Health Director or designee.

2. The hospitals shall encourage and facilitate the involvement of the case managers in the treatment team process, by providing, among other services, notification of

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treatment plan conferences or 90-day reviews no less than two weeks prior to the date of the conference or review. The hospitals shall identify an appropriate treatment team member to function as the primary contact for the case manager or the case management team.

3. **A** treatment plan shall be used for planning services for each county patient, and it shall identify each goal, and objective for the patient with projected time lines for their completion. Development of the treatment plan shall be the responsibility of the hospital with county consultation as requested. The county case manager is to review the treatment plan and indicate in writing his/her agreement or disagreement. The treatment plan shall be developed in accordance with the following requirements:

   a. The plan shall address reasons for admission.

   b. Patient treatment and stabilization directed toward expediting discharge shall be considered the desired outcome for all county patients, and all interventions shall relate to achieving discharge.

   c. Any special treatment needs shall be addressed in the treatment plan.

   d. The hospitals shall provide programs, which assist patients in achieving the objective of returning to a ,level of community living, (i.e., a facility offering a protective environment, a residential facility, a board and care facility, independent living, etc.).

   e. The treatment plan shall identify responsibility for each item included in the plan.

   f. The treatment plan shall not be changed solely based upon staffing changes within the hospitals.

   g. The county case manager/case management team shall be consulted whenever substantial changes to a patient's treatment plan are under consideration.

4. The case manager shall be encouraged to participate in treatment team meetings, clinical reviews or utilization review meetings and in clinical rounds which relate to county patients.

5. Primary criteria for continued treatment in the hospitals shall include, but not be limited to, the medical necessity of hospitalization within the state hospital setting, including LPS criteria, as reflected within the medical record. The County's Director of Mental Health or designee may conclude that a county patient no longer meets these primary criteria and may direct that the hospital discharge the patient to a facility the County determines to be more appropriate to the patient's treatment requirements. In such cases, discharge must occur within two (2) days of the date an alternative placement option is identified and available except as

provided in F (Admission and Discharge Procedures), item 2c of Exhibit A or otherwise required by law.

6. When agreement cannot be reached between case manager and the treatment team regarding .treatment, transfer, and/or discharge planning, the issues shall be referred to the hospital's Medical Director and the County Mental Health Director within three (3) days. On specific treatment issues the Medical Director's decision shall be final. Any agreement or program policy issues arising from discussions which are not resolved between the Medical Director and the County Mental Health Director may be referred to the Chief of Program Policy and Fiscal Support, Long Term Care Services within five (5) working days. The Chief will review the case with the County Mental Health Director. A response on the referred issue will be communicated to the County's Mental Health Director within two (2) working days after the Chief receives the documented basis for the appeal.

I. Bed Usage

1. During the 2003-04 fiscal year, the DMH shall provide, within the hospitals, specific numbers of beds dedicated to the care of only those patients referred by the County, including those admitted pursuant to Section 1370.01 of the PC and Murphy Conservatorships (Section 5008(h)(1)(B) of the WIC). The number and type of beds are specified in Exhibit B-Attachment.

2. For the purposes within this Agreement the term "dedicated beds" shall mean that the hospitals shall ensure that the number of beds contracted for by a county in a particular cost center category shall be available to the county at all times for patients who are appropriate for the services and facilities included in that cost center at the hospital to which the patient is being referred. The County expressly agrees that the hospital admissions, intra-hospital transfers, referrals to outside medical care, and discharges are made in accordance with the admission criteria established by the DMH and the counties, and the judgment of the hospital Medical Director or designee.

3. The County shall be considered to have exceeded its dedicated capacity on any given day on which more county patients are assigned to a cost center than the County has dedicated capacity in that cost center. The County shall only be permitted to use beds in excess of its dedicated capacity when use does not result in denial of access of other counties to their dedicated capacity. The County's use in excess of the Agreement amount shall be calculated as provided in Exhibit B-Attachment of this Agreement.

The DMH shall review the County's use of state hospital beds in accordance with this Agreement in January 2004, for the period July 1 through December 31, 2003, and in July 2004 for the period January 1 through June 30, 2004, to determine if the dollar value of the County's use has exceeded the dollar value of the County's contracted beds during the respective half year periods of this Agreement.

Excess use is established when the net dollar value of the County's actual use exceeds the contracted amount for the period under consideration. The County shall be obligated to pay the contract amount for the period or the dollar value of the County's actual use for the six-month period whichever is greater.

The County's obligation shall not be reduced below the contract amount set forth in Exhibit B-Attachment.

4. If the County does not contract for any state hospital beds, it may purchase access to a dedicated bed from other counties. Notwithstanding the fact that the County does not purchase any state hospital dedicated bed, the County shall be financially responsible for its use of state hospital resources resulting from, but not limited to, the conversion of PC commitments to Murphy Conservatorships (Section 5008(h)(1)(B) of the WIC).

5. There shall be no increase or decrease in the number of beds provided by the DMH within the hospitals and within a cost center, unless this Agreement is amended by mutual agreement.

6. When the County has a patient at Patton or Atascadero State Hospital, it shall use one of its vacant dedicated beds, in an equivalent cost center at its primary use LPS hospital, to cover the costs of that patient's care at Patton or Atascadero. If the County has no available. dedicated capacity, it must obtain the required capacity by purchasing it from a county that has available capacity in the proper cost center, purchase the services from the DMH as provided in the preceding item 3 or by amending this Agreement as provided herein.

7. The DMH, in consultation with the agencies who refer patients to the hospitals, may provide special programs for patients with unique needs, e.g., hearing impairment, Neurobehavioral problems, etc. The County may have access to these beds on a first come first served basis. If the County's dedicated capacity for the cost center in which the specialty unit(s) reside is all in use or if the County does not have any dedicated capacity in the cost center, the County may use any other of its available dedicated capacity to support the admission to the specialty unit(s).

J. Utilization Review

1. The hospitals shall have an ongoing utilization review program which is designed to assure appropriate allocation of the hospitals' resources by striving to provide quality patient care in the most cost-effective manner. The utilization review program is to address over-utilization, under-utilization, and the scheduling or distribution of resources. Hospitals that provide services which are certified for participation in the federal Medicare or Medi-Cal programs shall meet any additional requirements imposed by those certification regulations.

2 County representatives shall take part in the utilization review and performance improvement activities at the hospital program and unit level relating to county patients. County case manager participation in utilization review and discharge

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planning may include attendance at treatment team and program meetings. The hospitals shall include the County's monitoring of the quality and appropriateness of the care provided to county patients. Hospitals shall provide the County with information regarding the schedule of hospital-wide and patient specific utilization review activities. The hospitals shall also provide the County, upon request, summary aggregate data regarding special incidents.

3. Utilization review activities shall address the appropriateness of hospital admissions and discharges, clinical treatment, length of stay and allocation of hospital resources to most effectively and efficiently meet patient care needs.

K. Performance Improvement

1. The hospitals shall have ongoing Performance Improvement (PI) activities designed to objectively and systematically evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

2. The hospitals PI activities shall address all of the elements of QA which are required by applicable sections of the Title 22 of the CCR, Federal Medicare certification regulations, and the standards of JCAHO. The hospitals shall provide to the County summary data relating to aggregate review of incident reports, reports of untoward events, and related trend analysis.

3. PI activities shall address the quality of records, including but not limited to, quality review studies and analysis, peer review and medication monitoring procedures, drug use studies, medical care evaluation and standards studies, profile analysis and clinical care standards addressing patient care.

4. In accordance with the provisions outlined in J (Utilization Review), item 2, county representatives may take part in PI activities at the hospitals program and unit levels and in monitoring the quality and appropriateness of care provided to county patients.

L. Exchange of Information

1. The parties agree to make a good faith effort to exchange as much information as is possible, to the extent authorized by law. Such information may include, but not be limited to, medication history, physical health status and history, financial status, summary of course of treatment in the hospitals or county, summary of treatment needs, and discharge summary.

2. The exchange of information will apply only to patients referred by the County who are to be hospitalized, are currently hospitalized, or have been discharged from the hospital. Requests for information regarding any other patient must be accompanied by an authorization to release information signed by the patient.

M. Records

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1. Patient Records

The hospitals shall maintain adequate medical records on each individual patient. These medical records shall include legal status, diagnosis, psychiatric evaluation, medical history, individual treatment plan, records of patient interviews, progress notes, recommended continuing care plan, discharge summary and records of services provided by various professional and paraprofessional personnel in sufficient detail to permit an evaluation of services.

2. Financial Records

The DMH shall prepare and maintain accurate and complete financial records of the hospitals operating expenses and revenue. Such records shall reflect the actual cost of the type of service for which payment is claimed, on an accrual basis. Additionally, such records shall identify costs attributable to the County's LPS patients, versus other types of patients to whom the hospitals provide services. Any apportionment of or distribution of costs, including indirect costs, to or between programs or cost centers of the hospitals shall be documented, and shall be made in accordance with generally accepted accounting principles, and applicable laws, regulations and state policies. The patient eligibility determination and any fee charged to and collected from patients, together with a record of all billings rendered and revenues received from any source, on behalf *of* patients treated pursuant to this Agreement, must be reflected in the hospital financial records.

3. Retention of Records

a. All financial or patient records for patients who have not yet been discharged shall be retained until the patient has been discharged, at which time the record retention requirements in b through d below shall apply.

b. Financial records shall be retained by the DMH in accordance with the provisions of the State Administrative Manual, Section 1671. This section requires that most financial records, including CALSTARS reports, be kept two (2) years, after two (2) years they are to be kept until audited or four **(4)** years which ever occurs first. County financial records relating to this Agreement shall be retained in accordance with applicable law, regulation, and county policy.

c. Patient records for adults (age 18 and over) shall be retained by the DMH, for a minimum of seven (7) years from the date of discharge.

d. Patient records of persons under the age of eighteen (18) years who have been discharged shall be retained for one (1) year past the person's eighteenth (18th) birthday, or for seven (7) years, whichever is greater.

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e. Records which relate to litigation or settlement of claims arising out of the performance of this Agreement, or costs and expenses of this Agreement as to which exception has been taken by the parties to this Agreement, shall be retained by the parties until disposition of such appeals, litigation, claims, or exceptions are completed.

f. Except for records which relate to litigation or settlement of claims, the parties may, in fulfillment of their obligations to retain the financial and patient records as required by this Agreement, substitute photographs, micro-photographs, or other authentic reproductions of such records which are mutually acceptable to the parties, after the expiration and two (2) years following termination of this Agreement, unless a shorter period is authorized, in writing, by the parties.

N. Revenue

The County and the DMH agree to comply with all of the applicable provisions of Sections 7275 through 7278 of the WIC.

The DMH shall collect revenues from patients andlor responsible third parties, e.g., Medicare, Medi-Cal, and insurance companies, in accordance with the provisions of the above-cited sections of the WIC and related state laws, regulations and policies. When the County acts as the conservator of the patient and has control of the patient's estate it shall, on behalf of the patient's estate, pay the DMH for state hospital care in the same way that it pays other financial obligations of the patient's estate.

O. Inspections and Audits

1. Consistent with confidentiality provisions of Section 5328 of the WIC, any authorized representative of the County shall have reasonable access to the books, documents and records, including medical and financial records and audit reports of the DMH for the purpose of conducting any budget or fiscal review, audit, evaluation, or examination during the periods of retention set forth under M (Records) of Exhibit **A.** The County representative may at all reasonable times inspect or otherwise evaluate the services provided pursuant to this Agreement, and the premises in which they are provided. The County's Mental Health DMH shall not duplicate investigations conducted by other responsible agencies or jurisdictions, e.g., State Department of Health Services (Hospital Licensing), County Coroner's Office, District Attorney's Office, and other review or regulatory agencies. Practitioner specific peer review information and information relating to staff discipline is confidential and shall not be made available for review.

2. The hospitals shall actively cooperate with any person specified in paragraph I above, in any evaluation or monitoring of the services provided pursuant to this Agreement, and shall provide the above-mentioned persons adequate space to conduct such evaluation or monitoring. As each of the hospitals have contracts with several counties, the County agrees that the Executive Director of the

hospitals shall coordinate the access described in paragraph 1, above, in such a manner as to not disrupt the regular operations of the hospitals.

P. Notices

1. Except as otherwise provided in this Agreement, all notices, claims, correspondence, reports, and/or statements authorized or required by contract shall be effective when deposited in the United States mail, first class postage prepaid and addressed as specified in this Agreement.

2. The DMH has designated the Deputy Director, Long Term Care Services to be its Project Coordinator for all issues relating to this Agreement. Except as otherwise provided herein, all communications concerning this Agreement shall be with the Project Coordinator. The County has designated the following as its Project Coordinator and except as otherwise provided herein, all communication concerning this Agreement shall be with the County Project Coordinator:

Norm Wyman, MFT, Director

3. The hospitals shall notify the County immediately by telephone or FAX, and in writing, within twenty-four **(24)** hours of becoming aware of any occurrence of a serious nature which involves one of the county's patients. Such occurrences may include, but are not limited to, .homicide, suicide, accident, injury, battery, patient abuse, rape, significant loss or damage to patient property, and absence without leave.

4. The hospitals shall notify the County Mental Health Director or designee by telephone at the earliest possible time, but not later than three (3) working days after the treatment team determines that a patient **on** a PC commitment will likely require continued treatment and supervision under a County LPS commitment after the patient's PC commitment expires. Such telephone notification shall be followed by a written notification to the County Mental Health Director, or designee, which shall be submitted within ten (10) working days of the date the treatment team's determination that continued treatment and supervision should be recommended to the County. The written notice must include the basis for the hospital's recommendation and the date on which the PC commitment will expire. (See the following item 5.)

The above notices to the County Mental Health Director, or designee, shall be given not less than thirty (30) days prior to the expiration of the PC commitment. If the hospital does not notify the County at least thirty (30) days prior to the expiration of the PC commitment, the County's financial responsibility shall not commence until thirty (30) days after the hospital's telephone notification.

The County shall be responsible for making the decision regarding the establishment of an LPS commitment at the expiration of the PC commitment. The County shall notify the hospital, in writing, at least fifteen (15) days prior to the expiration of a patient's PC commitment of its decision regarding the establishment of an LPS commitment and continued hospitalization. If the County decides not to

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establish an LPS commitment or to remove the patient from the hospital, the County shall be responsible to transport the patient from the hospital back to the County or another treatment facility or residential placement.

5. The hospitals shall notify the County Mental Health Director, or designee, of the conversion of a patient on LPS status to a PC commitment status that results in the DMH becoming financially responsible for the placement of the patient and removes the patient from the County's dedicated capacity as defined in the preceding I (Bed Usage). The hospital shall notify the County Mental Health Director, or designee, by telephone at the earliest possible time, but not later than three (3) working days after such conversion. Such telephone notification shall be followed by a written notification to the County Mental Health Director, or designee, which shall be submitted no later than ten (10) working days after the patient's conversion.

6. For purposes of this Agreement, any notice to be provided by the County to the DMH shall be given by the County Mental Health Director or by other authorized representatives designated in writing by the County.

Q. Notification of Death

1. The hospital shall notify the County by telephone immediately upon becoming aware of the death of any person served hereunder, if the patient is an inpatient in the hospital or is on leave from the hospital but is still considered an inpatient at the time of death. However, such notice need only be given during normal business hours. In addition, the hospitals shall use its best efforts to, within twenty-four (24) hours after such death, send a FAX written notification of death to the County.

2. The telephone report and written notification of death shall contain the name of the deceased, the date and time of death, the nature and circumstances of the death, and the name of the hospital representative to be contacted for additional information regarding the patient's death.

II. SPECIFIC PROVISIONS

A. The DMH has designated the Deputy Director, Long Term Care Services for all issues relating to this Agreement, to be its Project Coordinator. Except as otherwise provided herein, all communications concerning this Agreement shall be with the Project Coordinator.

B. No amendment or modification to the terms and conditions of this Agreement, whether written or verbal, shall be valid unless made in writing and formally executed by both parties and approved by DMH.

Any amendments to this Agreement may include increases or decreases in the number of beds purchased within a cost center for the remainder of the current Agreement term. In the case of a decrease in the number of beds purchased within a cost center, the County will remain responsible for the fixed costs of the beds which

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are eliminated pursuant to such Agreement amendment, unless the DMH contracts these beds to another entity, in which case the County shall be absolved of all charges for such beds. In the case of an increase in the number of beds purchased within a cost center, the purchase cost shall be the rate established for those beds for the current fiscal year. .

C. The parties understand and agree that this Agreement shall not be terminated during its term. The provisions for altering this Agreement during its life are articulated in "B," above.

Section 4331 of the WIC defines the process to be followed in renewing the County's contract for state hospital services. The parties understand that this annual renewal process is for the purpose of ensuring an orderly adjustment in the use of state hospitals by the counties.

D. Should the DMH's ability to meet its obligations under the terms of this Agreement be substantially impaired due to loss of license to operate, damage or malfunction of the physical facilities, labor unions, or other cause, the DMH and the County shall negotiate modifications to the terms of this Agreement which ensure the safety and health of county patients.

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EXHIBIT B
STATE HOSPITAL BED PURCHASE AND USAGE

BUDGET DETAIL AND PAYMENT PROVISIONS

I. CONTRACT AMOUNT AND PAYMENT PROVISIONS

A. The amount payable by the County to the DMH concerning all aspects of this Agreement shall be $265,969. The amount reflected here was computed based on the information contained in the Exhibit B-Attachment. The amount represents the application of the "2003-04 Gross Rate to Counties", as published in a letter from DMH to Local Mental Health Directors dated August 6, 2003, entitled "STATE HOSPITAL RATES AND PLANNING ASSUMPTIONS FOR FISCAL YEAR 2003-04" which by this reference is made a part hereof, to the County's contracted beds, less $30.44 per day to reflect the application of anticipated revenue.

B. Any county bed use in excess of the contracted amount, as defined in Exhibit A, I (Bed Usage), during the 2003-24 fiscal year, shall be an additional cost to the County and collected by adjusting the State Controller's Schedule "B" in February 2004 and August 2004.

C. To the degree that revenue projections are not realized, the County shall be responsible for the cost of its state hospital use up to the "2003-24 Gross Rate to Counties" published in Enclosure A of the DMH letter referenced in A, above.

II. BUDGET CONTINGENCIES

A. This Agreement is subject to any restrictions, limitations, or conditions enacted by the Legislature and contained in the Budget Act or any statute enacted by the Legislature which may affect the provisions, terms, or funding of this Agreement in any manner. The DMH and the County mutually agree that if statutory or regulatory changes occur during the term of this Agreement which affect this Agreement, both parties may renegotiate the terms of this Agreement affected by the statutory or regulatory changes.

B. This Agreement may be amended upon mutual consent of the parties. A duly authorized representative of each party shall execute such amendments.

EXHIBIT B-ATTACHMENT

SANTA CRUZ COUNTY
STATE HOSPITAL COST COMPUTATION
July 1, 2003, through June 30, 2004

1. BEDS REQUESTED BY HOSPITAL, BY COST CENTER

Cost Center	Metropolitan	Napa	Total
Acute Psychiatric/Spec.	0	N/A	0
Youth Services	0	N/A	0
Continuing Medical Care (SNF)	0	1	1
ICF-Psychiatric Subacute	0	1	1
Total Beds Requested	**0**	**2**	**2**

2. COUNTY NET RATE FOR 2003-04

Cost Center	Metropolitan	Napa
Acute Psychiatric/Spec.	$389.58	N/A
Youth Services	$423.85	N/A
Continuing Medical Care (SNF)	$337.17	$381.00
ICF-Psychiatric Subacute	$359.79	$345.69

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3. TOTAL COMPUTED COSTS FOR CONTRACTED BEDS

Methodology: Multiply the county net rate times 366 to find the annualized cost for the cost center. Multiply the annualized cost times the number of beds requested in the cost center to find the annual total cost per cost center.

Cost Center	Metropolitan	Napa	Total
Acute Psychiatric/Spec.	$0	N/A	$0
Youth Services	$0	N/A	$0
Continuing Medical Care (SNF)	$0	$139,446	$139,446
ICF-Psychiatric Subacute	$0	$126,523	$126,523
Total County Costs	**$0**	**$265,969**	**$265,969**

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EXHIBIT B-ATTACHMENT

SANTA CRUZ COUNTY
STATE HOSPITAL COST COMPUTATION
July 1, 2003, through June 30, 2004

4. NET UTILIZATION CALCULATION METHODOLOGY

For the 2003-04 State Hospital Bed Purchase and Usage Standard Agreement the following methodology will be used to calculate the County's use of state hospital resources, if any, in excess of the contract amount specified in this Agreement.

A. Excess use will be calculated twice during the fiscal year, once in January 2004 for the first six (6) month period and again in July 2004 for the second six (6) month period. The State Controller will be directed to make an adjustment in the Schedule "B" for the county to reflect any excess use charge.

B. The total cost of the County's actual use in all cost centers at Napa and Metropolitan State Hospitals for the six-month period will be calculated. County LPS patients at Atascadero or Patton State Hospitals are charged to the ICF-Psychiatric Subacute cost center at the County's hospital of primary use – Metropolitan or Napa State Hospital. The County will be charged the contract amount or the actual cost of the County's state hospital use whichever is greater.

5. BASE CONTRACT AMOUNT

The total of item #3 on page 1 is $265,969. This amount appears in I, A of Exhibit B. This amount may be increased as indicated above and to reflect any required adjustment in the $30.44 per day offset as described in Exhibit B.

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EXHIBIT D
STATE HOSPITAL BED PURCHASE AND USAGE

SPECIAL TERMS AND CONDITIONS

I. TERM

The term of the Fiscal Year 2003-04 State Hospital Bed Purchase and Usage Agreement shall be July 1, 2003, through June 30,2004.

II. SETTLEMENT OF DISPUTE

Should a dispute arise relating to any issue within this Agreement, the County shall provide written notice specifying the details of the dispute to:

Deputy Director, Long Term Care Services
Department of Mental Health
1600 9th Street
Sacramento, CA 95814

Such written notice shall reference this Agreement, including the Agreement number. The Deputy Director, or his designee, will consult with the County and review the factors in the dispute before providing a written response to the County. The County shall complete this dispute resolution process prior to exercising any other remedies which may be available, except those described in Exhibit B, I, item B (Contract Amount and Payment Provisions).

III. INDEMNIFICATION AND INSURANCE

A. Except as provided in the following paragraph B and to the extent authorized by law, and as provided for in Section 895 of the California Government Code the DMH shall indemnify and hold harmless the County, its officers, agents and employees from all claims, losses and demands or actions for injury or death of persons or property damage arising out of acts or omissions of the DMH, its officers, agents or employees in performance related to the provisions of this Agreement.

B. County warrants that it is self-insured or maintains policies of insurance placed with reputable insurance companies licensed to do business in the State of California which insure the perils of bodily injury, medical, professional liability and property damage. The County shall indemnify and hold harmless and defend the state, its officers, agents and employees from all claims, losses and demands or actions for injury or death of persons or damages to property arising out of acts or omissions of the County, its officers, agents or employees in performance related to this Agreement.

IV. CONFIDENTIALITY

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A. The parties to this contract shall comply with applicable laws and regulations, including but not limited to Section 5328 et seq. of the WIC regarding the confidentiality of patient information.

B. The parties shall protect, from unauthorized disclosure, names and other identifying information concerning persons receiving services pursuant to this Agreement, except for statistical information.

C. The County agrees to comply with the provisions of Public Law 104-191 known as The Health Insurance Portability and Accountability Act of 1996 **(HIPAA),** and the HIPAA addendum to this Exhibit.

V. NONDISCRIMINATION

The DMH and the County shall not employ any unlawful discriminatory practices in the admission of patients, assignment of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference, or mental or physical handicap, in accordance with the requirements of applicable federal or state law.

VI. STATEMENT OF COMPLIANCE

The DMH and the County agree, unless specifically exempted, to comply with Government Code Section 12900 (a-f) and Title 2, Division 4, Chapter 5 of the CCR in matters relating to reporting requirements and the development, implementation and maintenance of a Nondiscrimination Program.

VII. PATIENT'S RIGHTS

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

VIII. RECORDKEEPING

The parties agree to maintain books, records, documents, and other evidence necessary to facilitate contract monitoring and audits pursuant to Section 640, Title 9, of the CCR and DMH policy.

IX. RELATIONSHIP OF THE PARTIES

The DMH and the County 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 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.

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The DMH, its agents and employees., shall not be entitled to any rights or privileges of County employees and shall not be considered in any manner to be county employees. The County, 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.

X. SEVERABILITY

If any provision of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction, or is found by a court to be in contravention of any federal or state law or regulation, the remaining provisions of this Agreement or the application thereof shall not be invalidated thereby and shall remain in full force and effect, and to that extent the provisions of this Agreement are declared severable.

XI. 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 Agreement 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 Agreement.

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EXHIBIT E
STATE HOSPITAL BED PURCHASE AND USAGE

HIPAA COMPLIANCE

A. The DMH shall comply with, and assist the County, in complying with, the privacy requirements of the HIPAA (including but not limited to 42 U.S.C. 1320d et seq., and its implementing regulations (including but not limited to 45 CFR Parts 142, 160, 162, and 164), hereinafter collectively referred to as the "Privacy Rule." Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms that are used in the Privacy Rule.

B. Except as otherwise limited in this Agreement, DMH may use or disclose Protected Health Information (PHI) to perform functions, activities, or services for or on behalf of the County as specified in this Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by the County.

C. The DMH shall not use or further disclose PHI other than as permitted or required by this Agreement or as required by law.

D. The DMH shall use appropriate' safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.

E. The DMH shall report to the County any use or disclosure of PHI not provided for by this Agreement.

F. The DMH shall mitigate, to the extent practicable, any harmful effect that is known to DMH of a use or disclosure of PHI by DMH in violation of the requirements of this Agreement.

G. The DMH shall ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by DMH on behalf of the County agrees to the same restrictions and conditions that apply through this Agreement to DMH with respect to such information.

H. The DMH shall provide access, at the request of the County, and in the time and manner designated by the County, to PHI in a Designated Record Set, to the County or, as directed by the County, to an individual in order to meet the requirements under 45 CFR 164.524.

I. The DMH shall make any amendment to PHI in a Designated Record Set that the County directs or shall pursuant to 45 CFR 164.526 at the request of the County or an Individual, and in the time and manner designated by the County.

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J. The DMH shall document such disclosures of PHI and information related to such disclosures as would be required for the County to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

K. The DMH shall provide to the County or an Individual, in time and manner designated by the County, information collected in accordance with subsection J to permit the County to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

L. The DMH shall make internal practices, books, and records relating to the use and disclosure of PHI received from or created by DMH on behalf of the County, available to the County, or at the request of the County to the Secretary of the United States Department of Health and Human Services ("Secretary"), in a time and manner designated by the County or the Secretary, for'purposes of the Secretary determining the County's compliance with the Privacy Rule.

M. Disposal of Information:

1. Except as provided in subparagraph 2 of this section, upon termination of this Agreement for any reason, DMH shall return or destroy all PHI received from the County, or created or received by DMH on behalf of the County. This provision shall apply to PHI that is in the possession of subcontractors or agents of DMH. DMH, its agents and subcontractors shall retain no copies of the PHI.

2. In the event that DMH determines that returning or destroying the PHI is infeasible, DMH shall provide to the County notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible, DMH shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as DMH, or any of its agents or subcontractors, maintains such PHI.

The respective rights and obligations of DMH concerning the Privacy Rule, including but not limited to the provisions of this Section, shall survive the termination of this Agreement.

N. The Parties agree to take such action as is necessary to amend this Agreement from time-to-time as is necessary for the County to comply with the requirements of the Privacy Rule or any other requirements of HIPAA and its implementing regulations.

COUNTY OF SANTA CRUZ
REQUEST FOR APPROVAL OF AGREEMENT

0542

TO. Board of Supervisors
County Administrative Office
Auditor Controller

FROM: **Health Services Agency** (Department)

BY: _____ (Signature) 5/19/04 (Date)
Signature certifies that appropriations/revenues are available

AGREEMENT TYPE (Check One) Expenditure Agreement ☐ Revenue Agreement ☐ ✓

The Board of Supervisors is hereby requested to approve the attached agreement and authorize the execution of same.

1. Said agreement is between the **Health Services Agency - Mental Health** (Department/Agency)

and **Santa Cruz County Office of Education, 809 Bay Ave, Suite H, Capitola, CA, 95010** (Name/Address)

2. The agreement will provide **funding for mental health IEP school services**

3. Period of the agreement is from **July 1, 2003** to **June 30,2004**

4. Anticipated Cost Is $ **NA - estimated revenue of $587,622** ☐ Fixed ☐ Monthly Rate ☐ Annual Rate ☐ Not to Exceed

Remarks: _____

5. Detail: ☐ On Continuing Agreements List for FY ____ Page CC-____ Contract, No: R822 OR ☐ 1st Time Agreement
☐ Section II No Board letter required, will be listed under Item 8
☐ Section III Board letter required
☐ Section IV Revenue Agreement

6. Appropriations/Revenues are available and are budgeted in **363101** (Index) **1817** (Sub object)

NOTE: IF APPROPRIATIONS ARE INSUFFICIENT, ATTACHED COMPLETED AUD-74 OR AUD-60

Appropriations ~~are~~ are not available and ~~have been~~ will be encumbered.

Contract No: R 822

By: _____ Date: 6/3/04
Auditor-Controller Deputy

Proposal and accounting detail reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize

Chair of the Board of Supervisors (Dept/Agency Head) to execute on behalf of the

Health Services Agency (DepartmenVAgency)

Date: _____

By: _____
County Administrative Office

Distribution:
Board of Supervisors - White
Auditor Controller - Canary
Auditor-Controller - Pink
Department - Gold

ADM - 29 (8/01)
Title I, Section 300 Proc Man

State of California
County of Santa Cruz

I, Susan A. Mauriello ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz, State of California, do hereby certify that the foregoing request for approval of agreement was approved by said Board of Supervisors as recommended by the County Administrative Office by an order duly entered in the minutes of said Board on June 15 2004

By: Deputy Clerk

AUDITOR-CONTROLLER USE ONLY

CO_____ $_____

Document No.	JE Amount	Lines	H/TL	Keyed By	Date

TC110_____ $_____ I

Auditor Description	Amount	Index	Sub object	User Code

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MEMORANDUM OF UNDERSTANDING
BETWEEN
COUNTY OF SANTA CRUZ
AND
SANTA CRUZ COUNTY OFFICE OF EDUCATION

THIS MEMORANDUM OF UNDERSTANDING (MOU), entered into this 2ND day of February, 2004, which date is enumerated for purposes of reference only, is by and between the COUNTY OF SANTA CRUZ (COUNTY) and SANTA CRUZ COUNTY OFFICE OF EDUCATION (SCCOE). This MOU shall be administered by the County of Santa Cruz Health Services Agency (ADMINISTRATOR).

WHEREAS, Government Code Sections 7570, et seq. (Chapter 1747, Statutes of 1984) (Assembly Bill 3632) require COUNTY to provide mental health services which are identified within the individualized education plan (IEP) pursuant to Government Code Section 7572 et seq.;

WHEREAS, since 1984 COUNTY has provided mental health services pursuant to AB 3632;

WHEREAS, COUNTY and Special Education Local Plan Areas (SELPAs) enter into an Interagency Agreement(s) for services pursuant to Government Code Section 7570 et seq. which are reviewed annually;

WHEREAS, AB 1765 (Chapter 157, Statutes of 2003) provides Federal IDEA funds for mental health services pursuant to Government Code Sections 7570 et seq. through county offices of education, which in Santa Cruz County is SCCOE;

WHEREAS, AB 1765 requires SCCOE to contract with COUNTY for the purpose of transferring these funds in their entirety to COUNTY to provide specified mental health services to eligible students;

WHEREAS, this funding shall be considered offsetting revenue within the meaning of Government Code Section 17556(e) for any reimbursable mandated cost claim for the provision of these mental health services provided in the 2003-2004 fiscal year;

WHEREAS, these funds shall be used exclusively for purposes of funding mental health services, which are related to an IEP, in 2003-2004; and

WHEREAS, AB 1765 states that it is the intent of the Legislature that the allocation be in effect for the 2003-2004 fiscal year only;

NOW, THEREFORE, it is mutually agreed as follows:

A. COUNTY shall submit an invoice to SCCOE requesting all funds specified in the local allocation prescribed under AB 1765.

B. Upon its receipt of funds, SCCOE shall transfer to COUNTY the local allocation prescribed under AB 1765 for fiscal year 2003-2004 in its entirety.

C. COUNTY shall deposit these funds into a separate account for the purpose of identifying expenditures incurred for the provision of mental health services pursuant to this MOU.

D. COUNTY shall provide an accounting to SCCOE of expenditures incurred pursuant to this MOU.

E. This MOU pertains only to the enactment of funding and other provisions of AB 1765 and shall terminate on June 30,2004.

F. GENERAL ASSURANCES – By executing this MOU, both parties agree that the General Assurances and Federal Funds Conditions specified in Attachment 1 will be observed.

IN WITNESS WHEREOF, the parties have caused this Memorandum of Understanding to be executed by their duly authorized officers in the County of Santa Cruz, State of California.

SANTA CRUZ COUNTY OFFICE OF EDUCATION

BY: _____ DATED 3/8/4

BARNEY FINLAY

TITLE: _____

COUNTY OF SANTA CRUZ

BY: _____ DATED _____

CHAIR OF THE BOARD OF SUPERVISORS

SIGNED AND CERTIFIED THAT A COPY
OF THIS DOCUMENT HAS BEEN DELIVERED
TO THE CHAIR OF THE BOARD.

_____ DATED 6/17/04

(NAME)
Clerk of the Board of Supervisors
of Santa Cruz County, California

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL
SANTA CRUZ COUNTY, CALIFORNIA

BY: _____ DATED 4/1/04

DEPUTY

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GENERAL ASSURANCES AND FEDERAL FUNDS CONDITIONS

The signature of the Authorized Official on the Certification of Acceptance of Grant Conditions acknowledges that General Assurances and Federal Funds Conditions will be observed.

General Assurances

1. Programs and services shall be in compliance with Title VI and Title VII of the U.S. Civil Rights Act of 1964, the California Fair Employment Practices Act, and Subchapter 4 (commencing with Section 30) of Chapter I of Division 1 of Title 5, California Code of Regulations. A statement of compliance with Title VI of the Civil Rights Act of 1964 has been filed with the County Office of Education.

2. Programs and services shall be in compliance with Title IX (nondiscrimination on the basis of sex) of the Federal Education Amendments of 1972 (20 U.S.C. 1681-1683) and subsequent amendments.

3. Programs and services shall be in compliance with the affirmative action provisions of the Federal Education Amendments of 1972 and subsequent amendments.

4. Programs and services shall be in compliance with the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.) and subsequent amendments.

5. Programs and services for disabled persons shall be in compliance with the Individuals with Disabilities Education Act, (20 U.S.C. Sec. 1400-1487, and attendant regulations) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

6. (a) When federal funds are made available, they will be used so as to supplement, and, to the extent practicable, increase the amount of state and local funds that would, in the absence of such federal funds, be made available for uses specified in the State Plan, and in no case supplant such state or local funds.
(b) The awardees shall ensure that federal funds are not used to reduce the level of expenditures for the preceding fiscal year as described in 34 CFR 300.231-300.232.

7. All state and federal statutes, regulations, program plans, and applications applicable to each program under which federal and state funds are made available through this application will be met by the applicant agency in its administration of each program, and the undersigned is authorized to file these assurances for such applicant agency.

8. The local agency will use fiscal control and fund accounting procedures that will ensure proper disbursement of, and accounting for, state and federal funds paid to that agency under each program.

9. The public agency shall make reports to the state agency or board and to the State Superintendent of Public Instruction as may reasonably be necessary to enable the state agency or board and the Superintendent to perform their duties and will maintain such records and provide access to those records as the state agency or board or the Superintendent deem necessary. Such records shall include, but not be limited to, records which fully disclose the amount and disposition by the recipient of those funds, the total cost of the activity for which the funds are used, the share of that cost provided from

other sources, and such other records as will facilitate an effective audit. The recipient shall maintain such records for five years after the completion of the activities for which the funds are used.

10. Any application, evaluation, periodic program plan, and/or report relating to each program will be made readily available to parents and other members of the general public.

11. Auditable records of each participating school program will be maintained on file at the district office. (5 C.C.R. 3944; 34 C.F.R. 74.24).

12. Each local agency shall have adopted policies and procedures consistent with Chapter 5.1 (commencing with Section 4600 of Division 1 of Title 5 of the California Code of Regulations) for investigation and resolution of complaints. Each LEA shall annually notify in writing, as applicable, its students, employees, parents or guardians of its students, the district advisory committee, school advisory committees, and other interested parties of their LEA complaint procedures, including the opportunity to appeal to the California Department of Education and the provisions of Chapter 5.1 (5 C.C.R. 4620-4632).

13. Any funds under any application program, which pursuant to paragraph (1), are available for obligation and expenditure in the year appropriated shall be obligated and expended in accordance with: (a) the federal' statutory and regulatory provisions relating to such program which are in effect for such succeeding fiscal year, and (b) any program plan or application submitted by such educational agencies for institutions for such programs for such succeeding fiscal year. "Obligations" are the amounts of orders placed, contracts and sub-grants awarded, services received, and similar transactions during a given period, which will require payment during the same or future period.

14. As required by Section 8355 of the California Government Code and Sections 701-707 of Chapter 10 of Title 41 of the United States Code, and implemented at 34 C.F.R. Part 85, Sections 85.600-635, to provide a drug-free workplace, the above named contractor or grant recipient will continue to provide a drug-free workplace by: (a) publishing 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, as defined at 34 C.F.R., Part **85,** Section 85.605 and 85.610; and (b) establishing a Drug-Free Awareness Program as required by the California Government Code Section 8355(b), to inform employees about all of the following: (1) the dangers of drug abuse in the workplace; (2) the person 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) provide as required by California Government Code Section 8355(c) that every employee who works on the proposed contract or grant: (1) will receive a copy of the company's drug-free workplace policy statement, and; (2) will agree to abide by the terms of the company's statement as a condition of employment on the contract or grant.

15. As required by Section 1352, Title 31 of the U.S. Code, and implemented at **34** C.F.R. Part 82, for prospective participants entering into a grant or cooperative agreement over $100,000, as defined at 34 C.F.R. Part 82, Sections 82.105 and 82.110, the applicant certifies that: (a) 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 any agency, a member of congress, an officer or employee of congress, or an employee of a Member of Congress in connection with the making of any Federal grant, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal grant or cooperative agreement; (b) 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, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal grant or cooperative agreement, the undersigned shall complete and submit Standard Form – LLL, "Disclosure Form to Report Lobbying," in accordance with these instructions; (c) the undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including sub grants, contracts under grants and cooperative agreements, and subcontracts) and that all sub recipients shall certify and disclose accordingly.

16. As required by Executive Order 12549, Debarment and Suspension, and implemented at 34 C.F.R. Part 85, for prospective participants in primary covered transactions, as defined at 34 C.F.R. **Part** 85, Sections 85.105 and 85.110. The applicant certifies that it and its principals: (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (b) have not within **a** three-year period preceding this application 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; (c) 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 (15)(b) of this certification; and (d) have not within a three-year period preceding this application had one or more public transactions (Federal, State, or Local) terminated for cause or default; and
Where the applicant is unable to certify to any of the statements in this certification, he or she shall attach an explanation to this grant.

17. The following is required for all state grants:
Recipient, by signing this grant, hereby acknowledges the applicability of Government Code sections 16645 through 16649 to this agreement. Furthermore, Recipient, 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) recipient shall account for state funds disbursed for a specific expenditure by this grant to show that those funds were allocated to that expenditure; (c) recipient shall, where state funds are not designated as described in item b above, allocate on a pro rata basis all disbursements that support the grant program; (d) recipient makes expenditures to assist, promote, or deter union organizing, Recipient will maintain records sufficient to show that no state funds were used for those expenditures, and shall provide those records to the Attorney General

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upon request; and (e)recipient hereby certifies that no request for reimbursement, or payment under this agreement, will seek reimbursement for costs incurred to assist, promote, or deter union organizing.

Federal Funds Conditions

1. This award is valid and enforceable only if the United States Government makes sufficient funds available to the State for the current Fiscal Year for the purposes of this program. In addition, this award 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 award in any manner.

2. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this grant shall be amended to reflect any reduction of funds.

3. For purposes of compliance with the Office of Management and Budget Circular A-133 Compliance Supplement, the "State laws and procedures applicable to sub recipients" of the California Department of Education are those State laws, regulations, and procedures applicable to State agencies.

4. Section 80.21, Title **34,** of the Code of Federal Regulations allows the state's sub recipients to receive payments provided they demonstrate the willingness and ability to minimize the time elapsing between the receipt and disbursements of federal funds; otherwise, reimbursement is the preferred method of payment. Further, this section requires the state's sub recipients to promptly remit to the federal agency any interest greater than $100 that they earned on the payments. Additionally, if the state's sub recipients receive payments, Section 80.20(b)(7), Title 34, of the Code of Federal Regulations, requires them to follow procedures for minimizing the time between the receipt and disbursement of federal funds.

GRANT AWARD AO-400 (9/98)

RETURN TO: 0550

California Department of Education
Special Education Division – GRANTS
1430 N Street, Suite 2401
Sacramento, CA 95814

CDE GRANT NO.			
FY	PCA	VENDOR NO.	SUFFIX
03	4467	1044	01
CO. NO.	NON-SACS ACCT.	SACS Resource	SACS Rev. Object
44	8182	3328	8182

Grantee	Superintendent		
Santa Cruz County Office of Education	Diane Siri Mental Health		
Address	City	State	Zip
809 Bay Avenue, Suite H	Capitola	CA	95010-2199

AWARD INFORMATION - IDEA COUNTY MENTAL HEALTH SERVICES				CDE USE ONLY	
2003-2004	Original Award Amount	Amendment No. ___	Award Total	State Index Project W/P	0663 28/03
Grant Amount	$490.543		$490.543	CFDA No.	84.027A
Award Dates	Beginning: July 1,2003	Ending: June 30,2004		Fed. Cat. No.	H027A030116

Congratulations! You have been awarded a California Department of Education (CDE) Special Education Division Grant Award. Your program contact is Jan Martinez, Administrative Services Unit, at (916) 327-3546. If you have questions regarding the fiscal aspects of this award, please contact the Grants staff at (916) 327-3530, 327-3508, or 327-3676. The following conditions apply:

1. All approved project funds must be expended within the designated award period and for no more than the total amount indicated under the "Award Information" above. Encumbrances may be made at any time after the beginning date identified above. However, all funds must be expended or legally obligated by the above-stated ending date.
2. This grant shall be administered in accordance with the provisions of the Individuals with Disabilities Education Act (IDEA) and Education Department General Administrative Regulations (EDGAR). Furthermore, expenditures shall comply with all applicable provisions of federal, state and local rules, regulations, and policies related to the administration of, use of, and accounting for public school funds including, but not limited to, the *Education Code* of the State of California
3. Beginning October 2003, a new CDE accountability requirement necessitates that all grantees complete and return the Mid-Year Report by February 1,2004.
4. PLEASE NOTE: The first payment will not be issued until CDE has received this Grant Award (Form AO-400) signed certifying acceptance of grant conditions. Please return your Grant Award to CDE completed and signed within ten (10) days of receipt of your award. In addition, failure by grantee to submit the Grant Award certifying acceptance of grant conditions will result in the withholding of current-year payments.
5. The Business/Fiscal Officer for the Grantee shall submit a Final Expenditure Report within 60 days of the ending date of the grant. Upon our receipt of the Final Expenditure Report, up to 100 percent of the grant will be reimbursed. PLEASE NOTE: Failure to submit a Final Expenditure Report: a) within 90 days of the ending date will result in denial of 25 percent of the grant amount; b) within 180 days of the ending date will result in a billing from CDE for the entire amount of any grant funds paid; and c) prior to next year's (SFY 2004-2005) grant award issuance will result in no more than 25 percent of SFY 2004-2005 funds being released.
6. In light of the State's current budget crisis, you should be aware that the State Legislature is currently considering numerous proposals, including those made by the Governor. Many of these proposals could potentially reduce and/or defer funds available for current year programs, including the funds available for this award. This is to advise you that if the legislature takes action to reduce or defer the funding upon which this award is based, then this award will be amended accordingly.
7. General Assurances and Federal Funds Conditions are attached and hereby incorporated by reference.

CERTIFICATION OF ACCEPTANCE OF GRANT CONDITIONS

On behalf of the grantee named above, I accept this grant award. I have read the conditions contained in this grant notification letter and, if applicable, the assurances in the grant application packet, and I agree to comply with all requirements as a condition of grant funding.

Printed Name of Authorized Agent	Title	Telephone No.
BARNEY FINLAY	ASST. SUPT/BUSINESS	(831) 479-5227
Signature of Authorized Agent ▶		Date 1/28/04
Signature of the State Superintendent of Public Instruction ▶ Jack O'Connell		Date December 26,2003

Attachment: General Assurances and Federal Funds Conditions (Rev. 11-4-03)
cc: Business/Fiscal Officer - Mid-Year Report (New 10/03) and Final Expenditure Report (Rev. 10/03)
Special Education Administrator at County Office (SEACO)
Special Education Director at County Office
CFT P.A. Director

GRANT AWARD AO-400 (9/98) COPY

RETURN TO:

California Department **of** Education
Special Education Division – GRANTS
1430 N Street, Suite **2401**
Sacramento, CA **95814**

CDE GRANT NO.			
FY	PCA	VENDOR NO.	SUFFIX
03	4468	1044	01
CO. NO.	NON-SACS ACCT.	SACS Resource	SACS Rev. Object
44	8182	3327	8182

0551

Grantee	Superintendent		
Santa **Cruz County Office of Education**	**Diane Siri**		
Address	City	State	Zip
809 Bay Avenue, Suite H	**Cauitola**	**CA**	***950*10-2199**

AWARD INFORMATION - **IDEA MENTAL HEALTH ALLOCATION** PLAN

				CDE USE ONLY	
2003-2004	Original Award Amount	Amendment No. ___	Award Total	State Index Project W/P	223 **28/03**
Grant Amount	**$97,079**		**$97,079**	CFDA No.	**84.027A**
Award Dates	Beginning: **July 1,2003**	Ending: **June 30,2004**		Fed. Cat. No.	H027A030116

Congratulations! You have been awarded a California Department of Education **(CDE)** Special Education Division Grant Award. Your program contact is Jan Martinez, Administrative Services Unit, at **(916) 327-3546.** If you have questions regarding the fiscal aspects of this award, please contact the Grants staff at **(916) 327-3530, 327-3508,** or **327-3676.** The following conditions apply:

1. All approved project funds must be expended within the designated award period and for no more than the total amount indicated under the "**Award** Information" above. Encumbrances may be made at any time after the beginning date identified above. However, all funds must be expended or legally obligated by the above-stated ending date.
2. This grant shall be administered in accordance with the provisions of the Individuals with Disabilities Education Act **(IDEA)** and Education Department General Administrative Regulations (EDGAR). Furthermore, expenditures shall comply with all applicable provisions of federal, state and local rules, regulations, and policies related to the administration of, use of, and accounting for public school funds including, but not limited to, the *Education **Code*** of the State of California.
3. Beginning October **2003,** a new **CDE** accountability requirement necessitates that all grantees complete and return the Mid-Year Report by February 1,2004.
4. PLEASE NOTE: The first payment **will** not be issued until CDE has received this Grant Award (Form AO-400) signed certifying acceptance of grant conditions. Please return your Grant Award to **CDE** completed and signed within ten **(10)** days **of** receipt **of** your award. In addition, failure by grantee to submit the Grant Award certifying acceptance of grant conditions will result in the withholding of current-year payments.
5. The Business/Fiscal Officer for the Grantee shall submit a Final Expenditure Report within **60** days of the ending date of the grant. Upon our receipt of the Final Expenditure Report, up to 100 percent of the grant will be reimbursed. PLEASE NOTE: Failure to submit a Final Expenditure Report: a) within **90** days of the ending date will result in denial of 25 percent of the grant amount; b) within 180 days of the ending date will result in a billing from CDE for the entire amount of **any** grant funds paid; and c) prior to next year's (SFY 2004-2005) grant award issuance **will** result in no more than 25 percent of SFY **2004-2005** funds being released.
6. In light of the State's current budget crisis, you should be aware that the State Legislature is currently considering numerous proposals, including those made by the Governor. Many of these proposals could potentially reduce and/or defer funds available for current year programs, including the funds available for this award. This is to advise you that if the legislature takes action to reduce or defer the funding upon which this award is based, then this award will be amended accordingly.
7. General Assurances and Federal Funds Conditions are attached and hereby incorporated by reference.

CERTIFICATION **OF** ACCEPTANCE OF GRANT CONDITIONS

On behalf of the grantee named above, I accept* this *grant award, I have read the conditions contained in this grant notification letter and, f applicable, the assurances in the grant application packet, and I agree to comply with all requirements as a condition of grantfunding.

Printed Name of Authorized Agent	Title	Telephone No.
BARNEY FINLAY	ASST.SUPT/BUSINESS	(831 479-5227
Signature of Authorized Agent ▶		Date 1/28/04
Signature of **the** State Superintendent of Public Instruction ▶ Jack O'Connell		Date January **6,2004**

A (Rev. 11-4-03)

cc: Business/Fiscal Officer - Mid-Year Report (New 10/03) and Final Expenditure Report (Rev. 10/03)
Special Education Administrator at County Office (SEACO)
Special Education Director at County Office
SELPA Director

27

0552

COUNTY OF SANTA CRUZ
REQUEST FOR APPROVAL OF AGREEMENT

TO. Board of Supervisors
County Administrative Office
Auditor Controller

FROM: **Health Services Agency** (Department)

BY: _____ (Signature) 5/19/04 (Date)
Signature certifies that appropriations/revenues are available

AGREEMENT TYPE (Check One) Expenditure Agreement ☐ Revenue Agreement ☐ ✓

The Board of Supervisors is hereby requested to approve the attached agreement and authorize the execution of same.

1. Said agreement is between the **Health Services Agency - Mental Health** (Department/Agency)
and **State Dept of Rehabilitation, 2000 Evergreen St, Sacramento, CA 95815** (Name/Address)

2. The agreement will provide **employment rehabilitation services**
State Contract 23202 amendment 3

3. Period of the agreement is from **July 1, 2001** to **June 30, 2004**

4. Anticipated Cost Is $ **57,955** ☐ Fixed ☐ Monthly Rate ☐ Annual Rate ☐ Not to Exceed

Remarks: **Auditor - reduce encumbrance by $58,042**

5. Detail: ☒ On Continuing Agreements List for FY **03 - 04** Page CC- **9** Contract, NO: **0603-01** OR ☐ 1st Time Agreement
- ☐ Section II — No Board letter required, will be listed under Item 8
- ☒ Section III — Board letter required
- ☐ Section IV — Revenue Agreement

6. Appropriations/Revenues are available and are budgeted in **363210** (Index) **3665** (Subobject)

NOTE: IF APPROPRIATIONS ARE INSUFFICIENT, ATTACHED COMPLETED AUD-74 OR AUD-60

Appropriations ~~are~~ / are not available and ~~have been~~ / will be encumbered.

Contract No: 30693-01

By: _____ Auditor-Controller Deputy Date: 6/3/04

Proposal and accounting detail reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize

Health Services Agency Director (Dept/Agency Head) to execute on behalf of the

Health Services Agency (DepartmenVAgency)

Date: _____

By: _____ County Administrative Office

Distribution:
Board of Supervisors - White
Auditor Controller - Canary
Auditor-Controller - Pink
Department - Gold

ADM - **29** (8/01)
Title I, Section 300 Proc Man

State of California
County of Santa Cruz

I, Susan A. Mauriello ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz, State of California, do hereby certify that the foregoing request for approval of agreement was approved by said Board of Supervisors as recommended by the County Administrative Office by an order duly entered in the minutes of said Board on June 15 20 04

By: Deputy Clerk

AUDITOR-CONTROLLER USE ONLY

CO Document No.	$ JE Amount	Lines	H/TL	Keyed By	Date
TC11 Auditor Description	$ Amount	Index	Sub object	User Code	

27

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213.4 (Rev 09/01)

AGREEMENT NUMBER	AMENDMENT NUMBER
23202	**3**
REGISTRATION NUMBER	0553

☐ **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED** _____ **Pages**

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

STATE AGENCY'S NAME
Department of Rehabilitation

CONTRACTOR'S NAME
Santa Cruz County Mental Health

2. The term of this Agreement is: July 1,2001 -**Through**- June 30,2004

3. The maximum amount of this Agreement is: **$** 0.00 F.Y. 2003/2004 - Cash Match: $57,955.00, Cert. Expend.: $120,815.00

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 herin:

Exhibit A, Attachment I-Program Budget Summary, Certified Expenditure Budget, Certified Expenditure Budget Narrative and Exhibit E are hereby replaced in its entirety with the attached Exhibit A, Attachment I-Program Budget Summary, Certified Expenditure Budget, Certified Expenditure Budget Narrative and Exhibit E.

This amendment is effective January 1, 2004.

All other terms and conditions shall remain the same.

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

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
Santa Cruz County Mental Health

BY *(Authorized Signature)* — DATE SIGNED *(Do not type)* 3/17/04

PRINTED NAME AND TITLE OF PERSON SIGNING
Rama Khalsa, Ph.D., Health Services

ADDRESS
P.O. Box 962, Santa Cruz, CA 95061

STATE OF CALIFORNIA

AGENCY NAME
Department of Rehabilitation

BY **(Authorized Signature)** Florence Hughes — DATE SIGNED *(Do not type)* 3-31-04

PRINTED NAME AND TITLE OF PERSON SIGNING
Florence Hughes, Chief, Contracts and Procurement

ADDRESS
2000 Evergreen Street, Sacramento, CA 95815-3832

CALIFORNIA
Department of General Services
Use Only

APPROVED
APR 14 2004
DEPT OF GENERAL SERVICES

☐ Exempt Per 27

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213A (Rev 09/01)

0554

☐ **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED** _____ **Pages**

AGREEMENT NUMBER	AMENDMENT NUMBER
23202'	**3**
REGISTRATION NUMBER	

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

STATE AGENCY'S NAME
Department of Rehabilitation

CONTRACTOR'S NAME
Santa Cruz County Mental Health

2. The term of this Agreement is: July 1,2001 -**Through**- June 30,2004

3. The maximum amount of this Agreement **is:** $ 0.00 F.Y. 2003/2004 - Cash Match: $57,955.00, Cert. Expend.: $120,815.00

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 herin:

Exhibit **A,** Attachment I-Program Budget *Summary*, Certified Expenditure Budget, Certified Expenditure Budget Narrative and Exhibit E **are** hereby replaced in its entirety with the attached Exhibit A, Attachment I-Program Budget Summary, Certified Expenditure Budget, Certified Expenditure Budget Narrative and Exhibit E.

This amendment is effective **January** 1, 2004.

All other terms and conditions shall remain the same.

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

CONTRACTOR

CONTRACTOR'S NAME (*If other than an individual, state whether a corporation,partnership, etc.*)
Santa Cruz County Mental Health

BY *(Authorized Signature)* | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Rama Khalsa, Ph.D., Health Services

ADDRESS
P.O. Box 962, Santa Cruz, CA 95061

Approved as to Form
By _____

STATE OF CALIFORNIA

AGENCY NAME
Department of Rehabilitation

BY (Authorized Signature) | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Florence Hughes, Chief, Contracts and Procurement

ADDRESS
2000 Evergreen Street, Sacramento, CA 95815-3832

CALIFORNIA
Department of General Services
Use Only

☐ Exempt Per _____

Exhibit A

COOPERATIVE AGREEMENT
BETWEEN
THE STATE OF CALIFORNIA
DEPARTMENT OF REHABILITATION
AND THE
SANTA CRUZ COUNTY DEPARTMENT OF MENTAL HEALTH

SCOPE OF WORK

I. INTRODUCTION

The Santa Cruz County Department of Mental Health (SCMH) and the California State Department of Rehabilitation (DOR) will combine staff resources to provide an integrated program of vocational rehabilitation services for individuals with severe psychiatric disabilities (hereinafter referred to as clients) who are mutually served by SCMH and DOR and who reside in the County of Santa Cruz.

The San Jose District Capitola Branch Office will provide DOR services. The SCMH operated North County and South County clinics and the local DOR staff will work collaboratively to provide services to mutual clients.

One (1) community-based case service contractor, Community Connections (CC), will provide clients with vocational assessment, personal vocational and social adjustment ,employment services, (employment preparation, job development, placement, follow along), and job coaching services.

The 1.5 FTE DOR SVRCs will collaborate with SCMH and CC staff to identify, assess, place and support program clients. Representatives from these agencies will work collaboratively including meeting regularly to discuss the program's progress and to staff cases. Staffs of both agencies will participate in cross training and in-service training programs for the purpose of increasing their capacity to work together and with clients served by this cooperative effort.

During fiscal year 2003-2004, there will be a total of **120** unduplicated DOR clients served through this cooperative agreement. **A** total of **90** new referrals will be made to the Department of Rehabilitation, DOR **will** complete **75** Individual Plans **for** Employment and **30** cases will be will be successfully closed. The goal is that **60%** of the clients whose cases are closed following plan initiation will have attained a successful employment outcome.

II. SERVICES **TO BE** PROVIDED

A. Cooperative Auxiliary Services

1. Description of Services

SCMH staff **will** provide Liaison Services to DOR clients from the North County and South County facilities. After the DOR case is open, SCMH staff **will** serve as a conduit for referral information SCMH staff will facilitate the provision **of** county mental health records to the DOR counselor to aid in the DOR clients eligibility determination and level **of** severity **of** disability **for** DOR services. They will be available to transport clients to initial interview meetings and serve as the clinic representative in cooperative program meetings. They will also be available to meet to discuss Severity **of** Disability Ratings, assist the DOR counselor and consumer in the development of the Individualized Plan for Employment, attend the Annual Review meeting, and meet with cooperative staff during our case closure/exit staffing when the client is successfully employed. The SCMH, DOR and Community Connections staff will collaborate throughout the life of the case and participate in case staffing as needed to support these clients.

2. Service Outcomes and Number to be Served

During fiscal year 2003-2004, it is expected the services identified above will be provided in **support** of **120** unduplicated DOR clients through SCMH.

This contract also provides for the following services through the

Case Service Contract with Community Connection of the Volunteer Center. These services are described in detail in the Case Service Contract.

B. Vocational Assessment

1. Description of Service: vocational assessment services will consist of client interview, vocational interest testing, review of client work history and related records, identification of barriers to community placement
2. Service outcomes/number to be served: **40** (unduplicated) individuals with psychiatric disabilities will receive **a** vocational assessment.

C. Personal, Vocational, and Social Adjustment

1. Description **of** Service; Support and vocationally-related intervention will be provided in order to assist individuals in the development of work-related functional skills, and in identifying and remediating barriers to success in employment
2. Service outcomes/number to be served: **80** (unduplicated) individuals with psychiatric disabilities will receive PVSA services during the contract year. **25** individuals will successfully complete each semester at Cabrillo College

D. Employment Services

1. Description of Service: The following activities are included as part **of ES:** ***Employment Preparation, Job Development and Placement*** services, and ***Post-Placement Follow-up*** services
2. Service outcomes/number to be served **60** (unduplicated) individuals with psychiatric disabilities will receive Employment Services during the contract year. **45** placements will be made in competitive jobs consistent with the IPEs **of** the individuals

E. Non-Supported Employment Job Coaching

1. Description **of** Service: Job coaching will consist of intensive support both on and off the job for as many hours per week as needed to assure job retention

2. Service outcomes/number to be served: **35** of the individuals placed will retain their jobs for at least **90** days. **15 of** the individuals successfully placed for **90** days will **be** private sector placements

III. Contract Administrators

Department of Rehabilitation	SC County Department **of** Mental Health
Rene Bloch 100 Paseo de San Antonio Ste 211 San Jose CA 95113 (408) 277-1098 rbloch@dor.ca.gov	Jack Young **1400** Emeline Street Santa Cruz **CA 95060** **(831)** 454-4520 **jayoung@health.co.santa-cruz.ca.us**

IV. Linkage to Other Community Agencies

SCMH and DOR will utilize linkages with local Workforce Investment Boards, Career (One Stop) Centers, Cabrillo College, adult schools, regional occupational programs, local chambers of commerce, and employer and client advocacy organizations in order to maximize resources and to increase the quality and quantity of clients who become successfully employed.

V. In-Service Training

SCMH in conjunction with the DOR will conduct ongoing in-service training opportunities for **SCMH,** DOR and case service contractor staff. For example, DOR will be providing **Job** Development training this fiscal year for contract staff. In addition, training and technical assistance will be provided or financed by both SCMH and DOR/DMH headquarters staff. Training will be based on the identified needs of programs, clients and SCMH and DOR staff. In addition, in-service training will be provided at the local level to cross-train cooperative program **staff in** each agency's mission, services, procedures, and professional approaches.

Santa Cruz County Mental Health

Attachment 1

Program Budget Summary
Fiscal Year 2003104
July 1, 2003 - June 30,2004

		TOTALS
DOR PROGRAM COSTS (From DOR Program Budget)		**$634,632**
TOTAL COOPERATIVE AGENCY EXPENDITURES (From Cooperative Agency Certified Expenditure Budget)		**$120,815**
TOTAL PROGRAM COST		**$766,347**
Certified Expenditure	25.01%	**$120,816**
DOR Share	75.00%	**$362,443**
Cash Expenditure	21.3%	**$67,966**
DOR Share	78.7%	**$214,134**
TOTAL BUDGET		**$766,347**

Source of Match funds: County General Funds
Cooperative agency certified expenditure and cash expenditure must be from non-Federal Funds and can not **be** used to draw down other Federal Funds. The cash expenditure must equal at least 21.3% of the designated share and the certified expenditure must equal at least 25% of the designated share.

COOPERATIVE AGENCY-CERTIFIED EXPENDITURE BUDGET

Fiscal Year 2003/2004

July 1, 2003-June 30, 2004

Contractor Name and Address	Cooperative agency agrees that it will make the following expenditures during the fiscal year ending June 30, 2004 in conformity with the following narrative section titled "Cooperative Agency-Certified Expenditure Budget Narrative". These are not legally mandated services and are not services that the Cooperative agency otherwise provides. **NOTE** No portion of the below expenditures shall come from Federal Funds.
Santa Cruz County Community Mental Health 1400 Emeline Avenue Santa Cruz, Ca. 95060	

Item Expenditure	FTE	Total Expenditure Dollars	Percent of Expenditure Devoted to Program	Amounts Chargeable to Program
PERSONNEL/POSITIONS				
Cooperative Program Mngr.	3	$206,204.50	9.15%	$ 18,867.71
Cooperative Clinic Supervisor	3.8	$209,235.50	13.28%	$ 27,786.47
Coop MH Client Specialist	17	$611,297	10.00%	$ 61,129.70
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
				$ -
OPERATING				
		NOT APPLICABLE		
			SUBTOTAL	$107,784
Indirect Cost/Administrative Overhead:	12.090%			$13,031
TOTAL EXPENDITURES "CERTIFIED" BY COOPERATIVE AGENCY (rounded to the nearest dollar):				$120,815

0560

Santa Cruz County Mental Health
Certified Expenditure Budget Narrative
FY 2003/2004

The following personnel will be assigned by **CMH** to the Cooperative Program, with the concurrence of the DOR contract administrator. These personnel will function for a specified portion of their time in a vocational rehabilitation role, and that portion of their time will be certified for use by **DOR** for federal matching purposes (see Cooperative Agency Certified Budget Summary). This role will involve the supervision and **support** of specific vocational rehabilitation services which are other than the traditional personnel **roles/services** of **CMH.** In order to identify the difference in function between their mental health role and their vocational rehabilitation role, the following comparisons are made between their traditional and new duties which constitute a new pattern of service.

One FTE constitutes a **40** hour per week employee, **or 2080** hours per year. The certified time below is based upon annual hours and **13.28% of 1** FTE equals **13.28%** of annual time worked Some weeks may include more or less hours than the weekly average.

<u>Program Manager</u>

Cooperative Program Duties:
Cooperative Program Manager
9.15 % of **3.0** FTE (1 FTE = 40 hrs. /wk.)

- Attends regular meetings with Cooperative Team
- Administrative Liaison for Cooperative Program needs

Traditional Mental Health Duties:
Program Manager
90.85 % of **3.0** FTE (1 FTE = 30 hrs. per/wk.)

- Manages Budget for Program
- Supervises clinic supervisor
- Insures policy and procedures
- Contract Liaison for community contracts.

Clinical Supervisor

Cooperative Program Duties:
Cooperative Clinical Supervisor
13.28 % of **3.8** FTE (1 FTE=40 hours/week)

- Participates in Cooperative case conferences
- Acts as clinical liaison for Cooperative Program Staff
- **Attends** regular meetings with Cooperative Team

Traditional Mental Health Duties:
Clinic Supervisor
86.72 % of **3.8** FTE (1FTE=40 hours/week)

- Responsible **for all clinical** issues **on** site
- Provides supervision **for all clinical** staff
- Reviews caseloads and appropriateness for target population
- Provides back up **for** crises coverage. Runs **weekly** staff meetings.

Mental Health Client Specialist [Coordinator)

Cooperative Program Duties:
Cooperative Mental Health Client Specialist
10.00% of **17.0** FTE **(1FTE=40 hours/week)**

- Provide conduit for referral information to DOR **counselor** after DOR case is opened.
- **Consult** with DOR counselor on **client DOR eligibility**
- **Consult** with DOR counselor on **client disability** severity
- Transport DOR **clients** to **initial** interviews
- Assist DOR **counselor** and **client** in **Individualized Plan** for **Employment development**
- Attend **DOR** case closure meetings
- Attends cooperative program meetings, as appropriate

Traditional Mental Health Duties:

Mental Health Client Specialist
90.00% of **17.0** FTE (1FTE=40 hours/week)

- Provide Mental health Services:

- **Assessment**
- **Individual REHAB counseling**
- **Individual Therapy**
- **Brokerage, to access needed medical, educational, social, prevocational, rehabilitative or other needed community services**

indirect costs associated with the above position are included. The indirect rate is from the latest Short-Doyle Medi-Cai Cost Report. This report is in a formal specified by the State of California Department of Mental Health for mental health services delivered by the county health systems.

Exhibit **E**

Additional Provisions

I. Contract Monitoring and Reporting

The DOR Contract Administrator will monitor this contract through quarterly cooperative meetings andlor other communication with the County Contract Administrator, Case Service Contractor, and DOR liaison staff. **DOR** and SCMH staff will attend quarterly meetings **to** assess progress towards goals, best practices and unresolved issues.

The cooperative agency will:

- Submit monthly certified expenditure invoices to the DOR contract administrator;
- Maintain cooperative communication with local county operated clinic staff, case service contract staff, and DOR liaison staff.
- Submit Personnel Activity Reports or time reporting documents as requested by DOR contract administrator
- Meet with **DOR** Contract Administrator and program staff to discuss contract progress on quarterly basis or as needed.

The DOR Contract Administrator will monitor the contract by:

- Review and approve certified expenditure invoices monthly as appropriate.
- Review monthly production and encumbrance reports;
- Periodically review personnel activity reports completed by certified time staff.
- Review contract objectives and contract services quarterly with the County Contract Administrator
- Sign and submit the invoices to Central Office Accounting with a copy to Collaborative Services Section **as** appropriate.

II. Transportation

The Santa Cruz County Department of Mental Health will be transporting DOR clients for the purposes of this contract.

COUNTY OF SANTA CRUZ
REQUEST FOR APPROVAL OF AGREEMENT

0565

TO, Board of Supervisors
County Administrative Office
Auditor Controller

FROM: Health Services Agency (Department)

BY: _____ (Signature) 5/25/04 (Date)
Signature certifies that appropriations/revenues are available

AGREEMENT TYPE (Check One) Expenditure Agreement Revenue Agreement ☐

The Board of Supervisors is hereby requested to approve the attached agreement and authorize the execution of same.

1. Said agreement is between the Health Services Agency - Mental Health (DepartmenUAgency)

and ValueOptions, 240 Corporate Blvd, Norfolk, VA, 23502 (NamelAddress)

2. The agreement will provide administrative services for use of vendor's provider network to deliver mental health services to county residents (children) placed in out-of-county foster care and group homes

3. Period of the agreement is from July 1, 2004 to continuous

4. Anticipated Cost Is $7,000 annually per rates in contract ☐ Fixed ☐ Monthly Rate ☐ Annual Rate ☐ Not to Exceed

Remarks: contract has no fixed maximum amount, expenditures are based upon amount of care delivered

5. Detail: ☐ On Continuing Agreements List for FY ___ Page CC-___ Contract, No: ~~43194~~ 43217 OR ☑ 1st Time Agreement

☐ Section II No Board letter required, will be listed under Item 8
☐ Section III Board letter required
☐ Section IV Revenue Agreement

Wr Required

6. Appropriations/Revenues are available and are budgeted in 363301 (Index) 3638 (Sub object)

NOTE: IF APPROPRIATIONS ARE INSUFFICIENT, ATTACHED COMPLETED AUD-74 OR AUD-60

Appropriations (are) / are not available and have been / encumbered.

Contract No: ~~43194~~ 43217

By: _____ Date: 6/3/04
Auditor-Controller/Deputy

Proposal and accounting detail reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize

Health Services Agency Director (Dept/Agency Head) to execute on behalf of the _____

Health Services Agency (DepartmenUAgency)

Date: _____

By: _____
County Administrative Office

Distribution:
Board of Supervisors - White
Auditor Controller - Canary
Auditor-Controller - Pink
Department - Gold

ADM - 29 (8/01)
Title I, Section 300 Proc Man

State of California
County of Santa Cruz
I, Susan A. Mauriello, ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz. State of California, do hereby certify that the foregoing request for approval of agreement was approved by said Board of Supervisors as recommended by the County Administrative Office by an order duly entered in the minutes of said Board on June 15 20 04

_____
By: Deputy Clerk

AUDITOR-CONTROLLER USE ONLY

CO	$				
Document No.	JE Amount	Lines	H/TL	Keyed By	Date

TC110	$	3638	/		
Auditor Description	Amount	Index	Sub object	User Code	27

MENTAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION AGREEMENT BETWEEN VALUEOPTIONS, INC. AND COUNTY OF SANTA CRUZ

This Agreement is by and between VALUEOPTIONS, INC., a Virginia corporation located at **240** Corporate Blvd., Norfolk, VA 23502 ("VALUEOPTIONS"or "ASO") on the one hand, and the County of Santa Cruz ("COUNTY'')on the other hand for administrative services related to the California Counties Medi-Cal Out-of-County Care Program (see below).

PREAMBLE

COUNTY has collaborated with its community partners to enhance the capacity of the health and human services system to improve the lives of children and families. These efforts require, as a fundamental expectation, that COUNTY's contracting partners share the COUNTY's and community's commitment to provide health and human services that support achievement of COUNTY's vision, goals, values, and adopted outcomes. Key to these efforts is the integration of service delivery systems and the adoption of customer service and satisfaction standards. COUNTY's vision is to improve the quality of life in the COUNTY by providing responsive, efficient, and high quality public services that promote the self-sufficiency, well-being and prosperity of individuals, families, businesses and communities.

W I T N E S S E T H

WHEREAS, COUNTY manages a State-authorized Mental Health Plan for the provision of Specialty Mental Health Services for Medi-Cal beneficiaries;

WHEREAS, one component of care provided by County includes Specialty Mental Health services for Medi-Cal beneficiaries who are minors and who reside out-of-home and/or out of their county of residence ("California Counties Medi-Cal Out-of-County Care Program", "California Counties" or "the Program");

WHEREAS, VALUEOPTIONS has established panels of health care providers who are qualified and appropriately licensed to provide Mental Health Services and other administrative services as an Administrative Services Organization ("ASO"); and

WHEREAS, County desires to engage VALUEOPTIONS as an Administrative Services Organization for management of a network of providers and provision of administrative services for that component of care provided by the County which includes Specialty Mental Health services for Medi-Cal beneficiaries who are minors and who reside out-of-home and out of their county of residence;

NOW THEREFORE, in consideration of the premises and the mutual promises herein contained, it is agreed as follows:

I. DEFINITIONS

1.1 **"Covered Services"** means Specialty Mental Health Services that are medically necessary and are covered for benefits by the Program.

1.2 **"Eligible Beneficiary"** means a minor who is an eligible Medi-Cal beneficiary and who resides out-of-home and/or outside their county of residence.

1.3 **"Specialty Mental Health Services"** means outpatient psychiatric and other outpatient mental health services for the treatment of mental health conditions to include the following specific services evaluation and assessment (CPT Code 90801), individual therapy (CPT Code 90806), individual therapy with medication management (CPT Code 90807), family therapy (CPT Code 90847), group therapy (CPT Code 90853), medication management (CPT Code 90862), case conference (CPT Code X9546) and psychological testing (CPT Code 96100).

1.4 **"Preferred Provider"** means a Provider who has: (i) met VALUEOPTIONS credentialing and recredentialing standards; (ii) contracted as an independent contractor with VALUEOPTIONS; (iii) agreed to accept the rate or fee agreed to with VALUEOPTIONS as payment in full for Covered Services, provided to Eligible Beneficiaries; and (iv) agreed to cooperate with VALUEOPTIONS regarding procedures incident to VALUEOPTIONS's administration of the Program.

11. RESPONSIBILITIES OF VALUEOPTIONS

2.1 **Scope of Services.** VALUEOPTIONS shall provide to COUNTY the services required of the administrative service organization of the Program in accordance with the attached Exhibit A "Scope of Services" which is attached hereto and incorporated herein by reference.

2.2 **Preferred Providers Network & Referrals for Specialty Mental Health Services.** VALUEOPTIONS will establish, maintain and administer a network of Preferred Providers ("the Network") for the delivery of Specialty Mental Health Services. The Network of Preferred Providers shall be composed of Providers of reasonably sufficient diversity to meet the cultural, linguistic and specialty needs of Eligible Beneficiaries. Preferred Providers shall be contractually required to continually meet VALUEOPTIONS credentialing standards including, but not limited to maintenance of licensure and applicable malpractice insurance, confirmation of status of provider as being eligible to provide services under federal programs, including Medicaid. A copy of the credentialing policies of VALUEOPTIONS shall be provided to COUNTY upon request. VALUEOPTIONS will contract with additional Preferred Providers as necessary to accommodate all Eligible Beneficiaries for whom services are required under this Agreement. This panel of Preferred Providers will be maintained throughout the term of this Agreement. Where VALUEOPTIONS does not have a Preferred Provider available, it will refer an Eligible Beneficiary to an appropriate Provider with whom appropriate arrangements shall be made for provision of all necessary Specialty Mental Health Services required by the Eligible Beneficiary. Such arrangements

by VALUEOPTIONS shall include a single case agreement and verification of provider's licensure and eligibility to participate as a provider in federal health programs, including, but not limited to, Medicaid.

VALUEOPTIONS shall maintain a Provider Handbook containing sections which detail policies and procedures for Preferred Providers and the delivery of Specialty Mental Health Services to Eligible Beneficiaries. This handbook shall include, but not be limited to, the following subject areas: Authorizations for Services, Claims Processing & Payment, Covered Services, Complaints & Grievances, and Psychological Testing.

2.3 **Psychological Testing Services.** VALUEOPTIONS, acting through its specialty clinical staff, including peer advisors, shall provide its clinical review services for Eligible Beneficiaries for whom psychological testing is requested. Any such request shall require completion of the Psychological Testing Request Form in Exhibit B which is attached hereto and incorporated herein by reference. VALUEOPTIONS shall review all requests for psychological testing and coordinate referral for such services to a qualified Participating Provider. The parties acknowledge that VALUEOPTIONS will not provide treatment to Eligible Beneficiaries, and that the final responsibility for all decisions concerning the provision of treatment will rest with the treating Provider and the Eligible Beneficiary.

2.4 **Claims.** VALUEOPTIONS shall provide the claims processing services set forth below in Article III of this Agreement.

2.5 **Toll-Free Telephone Number.** VALUEOPTIONS will maintain and make available to County, Eligible Beneficiaries and Providers a toll-free number seven days per week, twenty-four hours per day for the purposes of making requests for referrals, making requests for psychological testing and other inquiries, complaints or grievances. VALUEOFTIONS will refer Eligible Beneficiaries needing treatment to appropriate Preferred Providers or, where clinically appropriate and necessary, to other Providers.

Calls for referrals will require VALUEOPTIONS to verify the Eligible Beneficiary's eligibility status through the Medi-Cal website. VALUEOPTIONS shall bear no responsibility for erroneous or inaccurate information regarding eligibility obtained from Medi-Cal.

2.6 **Complaints & Grievances.** VALUEOPTIONS will maintain a system by which Eligible Beneficiaries and Providers may file a complaint or grievance with VALUEOPTIONS related to any issue arising out of VALUEOPTIONS role as ASO under this Agreement including, but not limited to, complaints regarding Preferred Providers. This system shall comport with the Complaints & Grievances Process document in Exhibit C which is attached hereto and incorporated herein by reference. VALUEOPTIONS will provide to Eligible Beneficiaries and Providers who file a complaint or grievance the contact information for COUNTY.

2.7 **Reports.** VALUEOPTIONS will make semi-annual Trend Reports available to COUNTY regarding the utilization and claims processing activities of VALUEOPTIONS for the

COUNTY in the form set forth in Exhibit D, which is attached hereto and incorporated herein by reference. Within sixty (60) days after the end of each semi-annual reporting period, VALUEOPTIONS will make available an annual report to **COUNTY** that provides composite data for the preceding year regarding the utilization and claims processing activities of VALUEOPTIONS on behalf of the **COUNTY.**

All reports shall be accessed by **COUNTY** through a secure website, established and maintained by VALUEOPTIONS solely for use of the Program and the counties participating in the Program with VALUEOPTIONS as ASO.

2.8 **Compliance with Laws.** VALUEOPTIONS shall comply with all applicable federal, state, and local laws applicable to the services provided under this Agreement.

III. CLAIMS PAYMENT; RESPONSIBILITIES OF VALUEOPTIONS

3.1 **Claims Payment Services.** VALUEOPTIONS will provide the following claims payment services:

(a) Receive and process claims with respect to Eligible Beneficiaries and determine the amount due and payable.

(b) Prepare checks drawn on a designated checking account in payment of valid claims to Preferred Provider or to such other person or assignee entitled thereto.

(c) Provide COUNTY with a copy of the check register or fund account statement itemizing the checks prepared in accordance with subsection (b).

(d) Mail checks prepared in accordance with subsection (b) to the appropriate payee upon receipt from **COUNTY** of sufficient funds.

(e) Maintain current and complete records and files of claim payments for each Eligible Beneficiary.

(f) Investigate and process any written requests or inquiries received for a review of denied claims and, where applicable, forward the information to **COUNTY** for review and decision on whether to pay or deny the claim.

(g) Maintain as confidential all claims, reports and other information and material furnished, obtained or developed in regard to its services under this Agreement.

(h) Furnish Form 1099 statements to health care providers and prepare reports regarding such statements as required by the regulations of the Internal Revenue Service.

3.2 **Errors in Claims Payment.** If any claim payment made by VALUEOPTIONS is not for the correct amount, VALUEOPTIONS will adjust any underpayment and attempt to recover any overpayment (other than through litigation). Except where the mistake or other action was the direct consequence of a lack of ordinary care or reasonable diligence on the part of VALUEOPTIONS or any if its directors, officers, or employees, VALUEOPTIONS and/or its directors, officers and employees will have no liability to COUNTY. The COUNTY, as payor, shall bear ultimate risk of loss for claims paid for Specialty Mental Health Services.

3.3 **Lack of Claims Funding Due to Eligibility.** VALUEOPTIONS shall not be responsible for any error or inaccuracy in eligibility information obtained through Medi-Cal. COUNTY shall not deny funding of claims payment or attempt to recover overpayments based on errors or inaccuracies in eligibility information from Medi-Cal. COUNTY bears ultimate responsibility as the payor for Specialty Mental Health Services.

3.4 **Benefit Payments.** Benefit payments for Specialty Mental Health Services furnished by Preferred Providers shall be calculated on the basis of the rates charged by a Preferred Provider in accordance with its agreement with VALUEOPTIONS. Schedules of these rates are included in Exhibit E, which is attached hereto and incorporated herein by reference. In all other respects, benefit payments shall be calculated in accordance with and governed by the relevant Services provided, with COUNTY having final claim determination authority. COUNTY bears ultimate responsibility as the payor for Specialty Mental Health Services.

3.5 **A. Wire Transfer of Funds.** Upon receipt of a copy of the check register or fund account statement from VALUEOPTIONS, in accordance with section 3.1(c), COUNTY shall wire transfer sufficient funds or provide a check payable with sufficient funds to the designated checking account to pay the checks included in such check register or fund account statement within ten (10) days. Such funding requests shall be made by VALUEOPTIONS to COUNTY twice a month. It is COUNTY's responsibility to transfer funds to the designated checking account in an amount adequate to cover all checks validly issued by VALUEOPTIONS according to this Agreement. VALUEOPTIONS will not mail the checks prepared in accordance with section 3.1(b) unless and until COUNTY transfers sufficient funds with which to pay such checks. COUNTY bears ultimate responsibility for payment of claims as the payor, VALUEOPTIONS shall not be liable for claims payment as a payor.

B. Pre-Payment of Funds. In lieu of Section 3.5 A above, COUNTY may elect to make a pre-payment of funds. If COUNTY elects to prepay, COUNTY shall make available sufficient funds in a designated bank. VALUEOPTIONS shall initiate a funds transfer via the Automated Clearing House (ACH) system, debiting the designated COUNTY bank account and crediting VALUEOPTIONS' bank account designated for the purpose of such claims payments. It shall be VALUEOPTIONS' responsibility to initiate the funds transfer. It shall be COUNTY's responsibility to adequately fund the bank account designated for this ACH debit and to permit VALUEOPTIONS to initiate such ACH debit transfers.

C. Pre-Payment of Funds. In lieu of Section 3.5 A and B above, COUNTY may elect to make a pre-payment of funds. If COUNTY elects to prepay, COUNTY shall forward a

warrant/check to VALUEOPTIONS on a semi-annual basis. VALUEOPTIONS shall deposit the funds in a bank account designated for purposes of payment of claims to providers of service. It shall be COUNTY's responsibility to reconcile the account balance to the check register or fund account statement with the advance. It shall be the COUNTY's responsibility to ensure that there are adequate funds to pay providers.

3.6 **Prior Claims Run-Out.** VALUEOPTIONS shall provide the above-referenced services related to processing and payment of claims for claims rendered prior to the effective date of this Agreement provided such claims are for dates of service on or after April 1, 2004. COUNTY agrees to meet all obligations of COUNTY specified in this Agreement for funding and payment of such claims.

IV. RESPONSIBILITIES OF COUNTY

4.1 Grant of Authority to VALUEOPTIONS. COUNTY hereby appoints VALUEOPTIONS as its agent for the sole and limited purpose of entering into agreements with Preferred Providers with regard to payment for Covered Services to Eligible Beneficiaries in accordance with the program set forth in this Agreement. COUNTY'sresponsibility shall extend only to an obligation for payment and COUNTY shall not be responsible for any action taken by VALUEOPTIONS in the selection of Providers, the administration (including termination) of such agreements or any other dealings with the Provider. Nothing contained in such agreements shall expand or increase COUNTY's obligation beyond that set forth in this Agreement or obligate COUNTY to make payment for any services that are not Covered Services.

4.2 **Delay in Furnishing Information.** VALUEOPTIONS will not be responsible for delay in the performance or nonperformance of services caused by or contributed to in whole or in part by the failure of COUNTY to furnish any required information promptly.

V. COMPENSATION

5.1 **Compensation.**

(a) Commencing July 1, 2004, on the last day of each month ("Due Date") thereafter during the term of this Agreement, COUNTY shall pay to VALUEOPTIONS a sum equal to $28.08 per month per Eligible Beneficiary for whom claims were paid in the preceding month as compensation for providing the VALUEOPTIONS ASO services described herein.

Notwithstanding the foregoing, if the underwriting assumptions change then VALUEOPTIONS' fees shall be subject to good faith renegotiation at the request of either party. A party may make a request for renegotiation on the basis of such change in the underwriting assumptions, only once per year.

(b) The compensation described in Section 5.1(a) shall not exceed the Contract Maximum that is listed in Exhibit G, which is incorporated by reference as if set forth fully herein. In the event COUNTY exceeds the Contract Maximum, VALUEOPTIONS shall be under no obligation to perform any further services to COUNTY. VALUEOPTIONS shall provide written notification to COUNTY when expenditures under this Agreement total seventy-five percent (75%) of the Contract Maximum.

(c) If COUNTY elects to prepay, COUNTY shall make a prepayment of the compensation described in Section 5.1(a) on or before July 9,2004. COUNTY shall make a second payment on January 7,2005.

VI. INDEMNIFICATION AND INSURANCE

6.1 **Indemnification.**

(a) In the event that COUNTY, its officers, directors, employees or agents are made parties to any judicial or administrative proceeding arising in whole or in part out of the negligent performance by VALUEOPTIONS of any of its obligations under this Agreement, then VALUEOPTIONS shall indemnify and hold COUNTY harmless for any and all judgments, settlements, and costs (including reasonable attorneys' fees) which COUNTY incurs or pays in connection therewith except that VALUEOPTIONS shall not be required to reimburse for such amounts to the extent that the court rendering the judgment or the agency making the award determines that the liability underlying the judgment or award (or attorneys' fees with respect thereto) was caused by the gross negligence, fraud or criminal conduct of COUNTY, its agents, employees, officers or directors. This provision is not intended to obligate VALUEOPTIONS to compensate COUNTY for claims for Covered Services or attorneys' fees that COUNTY may pay as a result of judicial or administrative proceedings contesting a denial of benefits based on VALUEOPTIONS good faith recommendation that payment be denied because services were not Medically Necessary.

(b) In the event that VALUEOPTIONS, its officers, directors, employees or agents are made parties to any judicial or administrative proceeding arising in whole or in part out of the negligent performance by COUNTY of any of its obligations under this Agreement, then COUNTY, shall indemnify and hold VALUEOPTIONS harmless for any and all judgments, settlements and costs (including reasonable attorneys' fees) which VALUEOPTIONS incurs or pays in connection therewith except that COUNTY shall not be required to reimburse for such amounts to the extent that the court rendering the judgment or the agency making the award determines that the liability underlying the judgment or award (or attorneys' fees with respect thereto) was caused by the gross negligence, fraud or criminal conduct of VALUEOFTIONS, its agents, employees, officers or directors.

(c) The indemnifications provided for by this Section shall survive the termination of this Agreement.

6.2 **Notice.** VALUEOPTIONS and COUNTY will promptly notify one another of any complaint or litigation of which each becomes aware in connection with any transaction covered by this Agreement. Within forty-eight (48) hours of receipt, each will forward to the other any notice of litigation or document referencing litigation or any complaint letter from any state insurance department or other governmental body.

6.3 **Defense of Litigation.** Except as provided in this Section VI, each party shall be responsible at its own expense for defending itself in any litigation brought against it, whether or not the other party hereto is also a defendant, arising out of any aspect of activities engaged in connection with this Agreement. Each party agrees to provide to the other party information in its possession, which is essential to the other party's defense in such litigation, to the extent allowed by law.

6.4 **Insurance.** VALUEOPTIONS shall maintain professional liability insurance coverage to insure it against any claim for damages arising out of any acts or omissions in connection with VALUEOPTIONS establishment or operation of the VALUEOPTIONS services specified herein. Such coverage shall not be less than five million dollars ($5,000,000) per occurrence and ten million dollars ($10,000,000) aggregate. VALUEOPTIONS shall maintain Comprehensive General Liability Insurance, Directors', Trustees' and Officers' Liability Insurance Policy and Automobile Liability Insurance that shall provide a minimum of one million dollars ($1,000,000) aggregate liability coverage for each policy year. VALUEOPTIONS shall also maintain Workers' Compensation Insurance at limits as may be required under the California Labor Code. County shall be named as an additional insured on the Commercial General Liability insurance policy. ValueOptions shall furnish County with evidence that foregoing insurance policies are in force and that the County is endorsed as an additional insured on the Commercial General Liability Insurance policy.

VII. TERM; TERMINATION

7.1 **Term.** Unless terminated as provided herein, this Agreement shall be for a term of one (1) year beginning on July 1, 2004 and ending on June 30, 2005. At least ninety (90) days prior to the expiration of this Agreement, upon mutual written agreement, the parties may extend the term of this Agreement for additional one-year periods, not to exceed five *(5)* years in total. The parties agree to negotiate in good faith the compensation listed in Section 5.1 prior to the commencement of any additional one year period.

7.2 **Termination For Breach.** COUNTY shall have the right to immediately terminate this Agreement upon written notice to VALUEOPTIONS in the event of a breach of the Agreement by VALUEOPTIONS. VALUEOPTIONS shall have the right to terminate this Agreement for cause at any time by giving the COUNTY thirty (30) days prior written notice

of a breach hereunder, provided that VALUEOPTIONS shall allow the COUNTY thirty (30) days in which to cure such breach. Should the COUNTY cure such breach to the reasonable satisfaction of VALUEOPTIONS on or before the effective date of termination, then this Agreement shall remain in full force and effect.

7.3 **Termination Without Cause.** Either party shall have the right to terminate this Agreement without cause by giving the other party sixty (60) days prior written notice. VALUEOPTIONS shall continue to make the Specialty Mental Health Services available to Eligible Beneficiaries during the sixty (60) day period following notice of termination without cause and COUNTY shall continue to pay VALUEOPTIONS during such sixty (60) days in accordance with the compensation set forth herein.

7.4 **Following Termination.** Following termination of this Agreement, VALUEOPTIONS will provide reasonable cooperation in the transition of its responsibilities to the entity selected by COUNTY to assume administration of the Specialty Mental Health Services. VALUEOPTIONS shall accept no new Eligible Beneficiary referrals from COUNTY after the effective date of such termination.

VIII. MISCELLANEOUS PROVISIONS

8.1 **Record Maintenance and Inspection.**

(a) VALUEOPTIONS shall prepare and maintain all appropriate records on Eligible Beneficiaries receiving Specialty Mental Health Services from Providers. The records shall be maintained in accordance with prudent record-keeping procedures and as required by law.

(b) VALUEOPTIONS agrees to allow COUNTY reasonable review of any data and other records it maintains on Eligible Beneficiaries that relate to this Agreement. COUNTY shall have full access to records relating to billing, payment and assignment, and access to medical records to the limited extent necessary to enable COUNTY to audit VALUEOPTIONS performance of its obligations under this Agreement. Such review shall be allowed upon reasonable notice during regular business hours and shall be subject to all applicable laws and regulations concerning the confidentiality of such data or records.

8.2 **Confidentiality of Clinical Records & HIPAA.** COUNTY and VALUEOPTIONS agree to maintain the confidentiality of any clinical records of Eligible Beneficiaries as required by State and Federal law, and COUNTY's and VALUEOPTIONS' confidentiality guidelines. In particular, VALUEOPTIONS and COUNTY agree to abide by the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations. Pursuant to HIPAA, VALUEOPTIONS and COUNTY hereby enter into a Business Associate Agreement as set forth in the attached Exhibit F, which is incorporated by reference as if set forth fully herein.

8.3 **Right of Audit.** COUNTY shall have the right upon reasonable notice at all reasonable times to audit and examine the records of VALUEOPTIONS which relate to this Agreement and the services provided hereunder insofar as such examination relates to, and is limited by, the transactions involving the services and compensation rendered under the terms of this Agreement. VALUEOPTIONS further agrees to cooperate and assist COUNTY in performance of an audit of a Preferred Provider, such audits being contemplated by the terms of the Preferred Providers contract with VALUEOPTIONS. Such audits may involve the reconciliation of eligibility, claims funding, compensation and fees as applicable. This right of audit may be exercised by the party, or by its duly authorized employee or agent or by an independent consultant designated by such party. The party requesting and conducting the audit shall bear all expenses of the audit which are not expenses incurred in the ordinary course of business.

8.4 **Operations of Parties.** All parties shall, throughout the term of this Agreement, use their best efforts to be in continuous compliance with all applicable laws and regulations.

8.5 **Proprietary Rights.**

(a) COUNTY acknowledges that VALUEOPTIONS and its subcontractor(s) and affiliate(s) have developed manuals, procedures, processes and information related to its services which are proprietary in nature and which constitute trade secrets of such party. COUNTY shall not use any such information or materials that may come into its possession other than as contemplated by this Agreement and in furtherance of its objectives.

(b) Neither party shall use the name, logos, trademarks or service marks of the other without the other's prior written consent, except that VALUEOPTIONS and its subcontractor(s) or affiliate(s) may include COUNTY in its listing of clients and COUNTY may use VALUEOPTIONS and VALUEOPTIONS' subcontractor(s) or affiliate(s) in its Plan materials.

8.6 **Disputes.** Any controversies or claims between COUNTY and VALUEOPTIONS arising out of or relating to this Agreement shall be submitted to non-binding mediation before a single mediator chosen by designated corporate officers of VALUEOPTIONS and officials of the COUNTY. The parties shall bear their own costs of mediation. Nothing contained in this provision shall be construed to give any Eligible Beneficiary any rights to mediate any dispute with COUNTY or VALUEOPTIONS regarding benefits payment or any other matter related to administration of the Program.

8.7 **Relationship of Parties.** The relationship of the parties under this Agreement shall be that of independent contractors. Neither shall have any claim under this Agreement or otherwise against the other party as a joint venturer or partner.

8.8 **Designated Representatives.** Each party shall designate in writing a representative who shall represent it in the day-to-day administration of this Agreement. Such designation may be changed by either party by written notice to the other party as provided for below.

8.9 **Entire Agreement.** This Agreement represents the entire Agreement between the parties and supersedes any and all previous written or oral agreements or understandings.

8.10 **Assignment.** Neither party may assign this Agreement, in whole or in part, without the prior written consent of the other party (which will not be unreasonably withheld), except that no such written consent will be required in connection with a change of control, merger or reorganization of a party, or a sale of all, or substantially all, of such party's assets. The parties agree that during the term of this Agreement, VALUEOPTIONS shall not subcontract any of its responsibilities under this Agreement. This section shall not be deemed to preclude VALUEOPTIONS, or its affiliates, from contracting with Affiliated Providers. Any attempted assignment of this Agreement, other than as permitted above, will be null and void, and will establish cause for termination of this Agreement as set forth in Section 7 hereof. This Agreement shall be binding on any successor in interest of either party.

8.11 **Waiver.** Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

8.12 **Notices.** Any notice required by this Agreement shall be given in writing to the liaison person designated by a party, sent by United States mail, return receipt requested, or by Federal Express, UPS, or other overnight mail service, with postage prepaid and addressed to each party at the addresses set forth on the signature page, or at any other address of which a party has given notice in accordance with this Section. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt if delivered by mail or the date upon which such notice is personally delivered in writing to the following designated liaison person:

for COUNTY:
Deputy Director, Mental Health and Substance Abuse
County of Santa Cruz
1400 Emeline Avenue
Santa Cruz, CA 95060

for VALUEOPTIONS:
Julie Larson
ValueOptions, Inc.
340 Golden Shore
Long Beach, CA 90802

Copy to VALUEOPTIONS designated Account Executive

8.13 **Administrative Procedures.** The parties shall mutually agree upon administrative procedures necessary to implement this Agreement.

8.14 **Governing Law.** With respect to the contractual rights between VALUEOPTIONS and COUNTY, this Agreement shall be governed by, and construed in accordance with, the laws of California, excluding any conflicts of law, rules or principles that might otherwise refer the same to the law of another jurisdiction. This Agreement has been entered into

and is to be performed in the County of Santa Cruz. Accordingly, the parties agree that the venue of any action relating to this Agreement shall be in the County of Santa Cruz.

8.15 **News Release.** Upon the execution of this Agreement by both parties, VALUEOPTIONS may write and distribute to the media and the general public a news release ("News Release") announcing the Agreement between VALUEOPTIONS and COUNTY. The News Release may be in any format. COUNTY shall have the opportunity to review and provide comments to VALUEOPTIONS on the News Release prior to its distribution provided that VALUEOPTIONS receives such comments with three (3) business days of providing the release to COUNTY. The COUNTY may appoint a spokesperson to provide a quote for the News Release. Unless otherwise agreed upon by VALUEOPTIONS and COUNTY, VALUEOPTIONS shall have final approval of the News Release content.

8.16 **Extraordinary Circumstances.** Neither party nor their subcontractor(s) or affiliate(s) hereto shall be held responsible for delay or failure to perform hereunder when such delay or failure is due to fire, flood, epidemic, strikes, acts of God or the public enemy, acts of terrorism, acts of war, unusually severe weather, legal acts of public authorities, or delays or defaults caused by public carriers, or other circumstances which cannot reasonably be forecast or provided against (collectively "Extraordinary Circumstances").

Notwithstanding anything to the contrary in this Agreement, in the event that an Extraordinary Circumstance occurs and VALUEOPTIONS is required to perform its obligations under the conditions caused by the Extraordinary Circumstance or to perform services not originally contemplated under the Agreement, then VALUEOPTIONS shall have the right to increase its compensation rate by an amount or percentage mutually agreed to by the parties in writing. Failure by the parties to mutually agree to an increased compensation rate within 30 days after initiation of renegotiation by VALUEOPTIONS, as set forth herein, may result in termination of the Agreement at the election of either party.

8.17 **Nuclear Ordinance.** If applicable, the Nuclear Free Ordinance of COUNTY prohibits COUNTY from entering into any contracts with any contractor who is knowingly or intentionally engaged in the research, weapons systems, or nuclear weapon components, as defined in the ordinance. Any contracts or agreements resulting from this agreement will contain a provision requiring the Contractor to certify that it is not a Nuclear Weapons Contractor, as defined by the Nuclear Free County Ordinance.

8.18 **Compliance with child, family and spousal support reporting obligations.** VALUEOPTIONS' failure to comply with state and federal child, family and spousal support reporting requirements regarding a VALUEOPTIONS' employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment relating to child, family and spousal support obligations shall constitute a default under this Agreement. VALUEOPTIONS' failure to cure such default within 90 days of notice by COUNTY shall be grounds for termination of this Agreement.

8.19 **Exclusion from participation in federally funded programs.** VALUEOPTIONS warrants that neither it nor any of its employees is restricted or excluded from providing services under any health care program funded by the federal government, directly or indirectly, in whole or in part, and that VALUEOPTIONS will notify **COUNTY** within thirty days of any event that would require its or an employee's mandatory exclusion from participation in a federally funded health care program.

8.20 **Nondiscrimination and affirmative action.** VALUEOPTIONS certifies and agrees that all persons employed by it, its affiliates, and subsidiaries are and shall be treated equally without regard to or because of race, color, religion, ancestry, national origin, sex, age, physical or mental disability, marital status, or political affiliation, and that it is in compliance with all applicable federal and state anti-discrimination laws and regulations.

8.21 **COUNTY Lobbyist Ordinance.** VALUEOPTIONS shall fully comply with **COUNTY's** Lobbyist Ordinance. Failure on VALUEOPTIONS' part to fully comply with such ordinance shall constitute a material breach of this Agreement, upon which **COUNTY** may, in its sole discretion, immediately terminate this Agreement.

8.22 **Debarment.** In the event **COUNTY** acquires information concerning the performance of VALUEOPTIONS on this or other Contracts which indicates that VALUEOPTIONS is not trustworthy and has not demonstrated the fitness, capacity, and experience to satisfactorily perform its services under this Agreement, **COUNTY** may, in addition to other remedies provided in this Agreement, debar VALUEOPTIONS from bidding or proposing on, or being awarded, and/or performing work on **COUNTY** contracts for a specified period of time not to exceed three years, and may terminate any or all existing contracts VALUEOPTIONS may have with **COUNTY.**

8.23 **Termination for Improper Consideration.** **COUNTY** may immediately terminate this Agreement if it is found that consideration, in any form, was offered or given by VALUEOPTIONS, either directly or through an intermediary, to any **COUNTY** officer, employee, or agent with the intent of securing this Agreement, or securing favorable treatment with respect to the Agreement, or the making of any determinations with respect to VALUEOPTIONS' performance pursuant to the Agreement.

8.24 Hiring County Employees. In the event VALUEOPTIONS requires additional or replacement personnel after the effective date of this Agreement, during the term of this Agreement, VALUEOPTIONS shall give first consideration for such employment openings to qualified permanent **COUNTY** employees who are targeted for layoff or are on a reemployment list.

8.25 **Recycled Paper.** In providing its services under this Agreement, VALUEOPTIONS agrees to use recycled paper to the maximum extent possible.

8.26 **Quality Assurance Plan.** **COUNTY** or its agent will evaluate VALUEOPTIONS' performance under this Agreement on not less than an annual basis. Such evaluation will

include assessing VALUEOPTIONS' compliance with all contract terms and performance standards. Deficiencies which COUNTY determines to be severe or continuing and that place performance of the Agreement in jeopardy if not corrected will be reported to the Board of Supervisors. The report will include improvement/corrective action measures taken by COUNTY and VALUEOPTIONS. If improvement does not occur consistent with the corrective action measures, COUNTY may terminate this Agreement.

8.27 Conflict of Interest. No *COUNTY* employee whose position in COUNTY enables such employee to influence the award or administration of this Agreement, and no spouse or economic dependent of such employee, shall be employed in any capacity by VALUEOPTIONS or have any direct or indirect financial interest in this Agreement. No officer or employee of VALUEOPTIONS.who may financially benefit from the provision of services hereunder shall in any way participate in COUNTY's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence COUNTY's approval or ongoing evaluation of such services.

VALUEOPTIONS shall comply with all conflict of interest laws, ordinances and regulations now in effect or hereafter to be enacted during the term of this Agreement. VALUEOPTIONS warrants that it is not now aware of any facts which create a conflict of interest. If VALUEOPTIONS hereafter becomes aware of any facts which might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to COUNTY. Full written disclosure shall include, without limitation, identification of all persons implicated and complete description of all relevant circumstances.

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date set **forth** herein above.

COUNTY OF

By: RAMA KHALSA

Title: HSA DIRECTOR

Date: 6/15/04

Approved As To Form:
County Counsel

Approved as to Insurances:
Janet McKinley Risk Management
5-18-04

VALUEOPTIONS, INC.

By:

Title: Vice President

Date: 6/22/04

EXHIBIT A

California Counties/The ASO Scope of Services

ASO Program Benefit Administration:

- Valueoptions will administer (routine) outpatient specialty mental health services for full scope out-of-county youth, ages 0 through 18, in California.
- Customer service 800 phone number
- 24 hours a day/365 days a year service
- Dedicated Full-Time Account Manager
- Dedicated IT and Eligibility Analysts
- Peer Advisor/Psychologist for Psychological Testing Pre-authorization
- Customized Valueoptions Website (standard format across all counties)
- Semi-Annual and Annual Reporting (standard format across all counties)
- ASO Provider Network (credentialing/recredentialing)
- Quality Review and Management Program (standard across all counties)
- Bi-monthly provider claims payment (county funding within 10 business days of check run)
- Telephone abandonment rate of less than 3%
- Telephone average speed of answer of 20 seconds or less
- Routine appointments within 7 calendar days

Operational Functions:

- The ASO will be responsible for providing the following services functions to caregivers, and providers:

    - Claims payment information, and problem resolution
    - Routine outpatient mental health authorizations
    - Authorization Status
    - Ongoing procedural education

Contract:

- The ASO and the California Counties will adhere to the terms in the contract from July 1,2004 through June 30,2005.

Provider Network:

- The ASO will maintain a network of providers that meets the cultural, linguistic and specialty needs of the population.
- The ASO will assist California Counties in obtaining medical records from providers to the extent of the attached workflow (see attachment **A-1** at end of Exhibit).

Claims:

- Claims will be processed and paid from the ASO to the providers. California Counties will provide the ASO with funds for bi-monthly check runs.

- The ASO will provide California Counties with standard invoices documenting the request for claims funding accompanied by a Paid Claims Report

- The ASO will submit invoices to California Counties on a bi-monthly basis.

Authorizations:

- Authorizations time span for professional therapy services will be 13 units over 3-month period.
- Authorizations time span for pharmacological management will be 7 units over 6-month period.

Internet Usage:

- ValueOptions recognizes the need for the careful handling of member information, particularly as it relates to behavioral health treatment. ValueOptions is deploying an Internet based solution for the transmission of data between ValueOptions and California Counties. It is ValueOptions full intent to implement adequate Internet security including encryption, authentication and a management scheme that incorporates password/key management systems.

Proposed Workflow for CA Counties Medical Records Request

Last Updated by Jill Craig, Monday, May 17, 2004

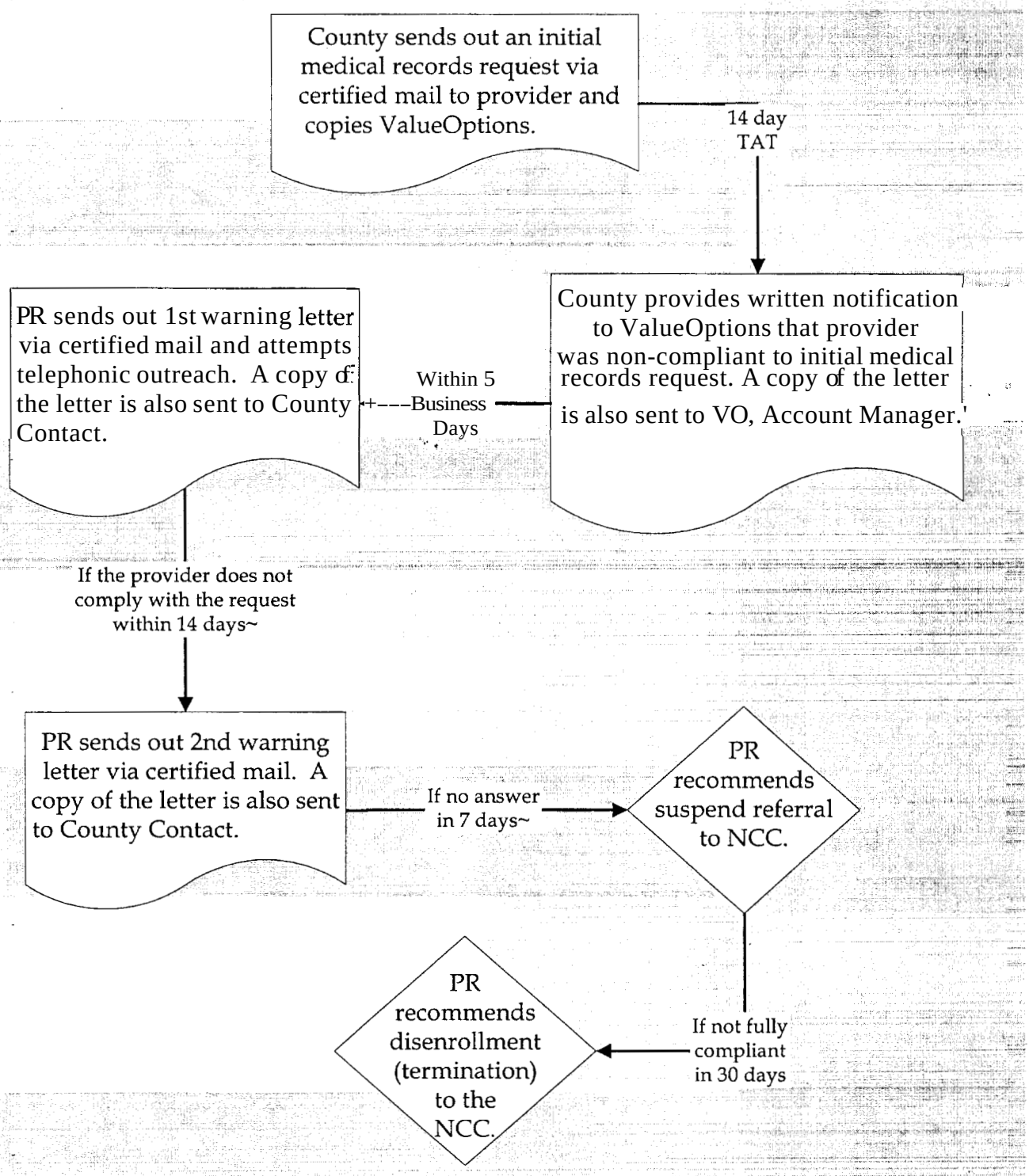

EXHIBIT B

See attached Psychological Testing Request Form

ValueOptions

0584

Request For Medical Necessity Determination For Psychological Testing

Patient Name

Date of Birth

Employee's Name

Employer

Employee's Address

Employee SSN

Patient's Relationship *to* Employee

Name of Psychological Tester Network Non-Network

Discipline & State License and Number

Are you independently licensed? Yes No

Address

Telephone Number

City/State/Zip

Tax I.D. Number

Name of Therapist (if different from above)

Network Non-Network

Discipline & State License and Number

Are you independently licensed? Yes No

Address

Telephone Number

City/State/Zip

Tax I.D. Number

A. (l.) Who initiated referral? (If MD, what is MD's specialty?) _____

(Ii.) What are the referral questions? _____

B. Current possible DSM-TV Diagnosis under evaluation:

Diagnosis: Axis I: _____ Axis II: _____ Axis III: _____

Axis IV: _____ Axis V *(current):* _____ *(highest in 12 months):* _____

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C. History of patient *(Summary of psychosocial/medical info. and past treatment; include any past psychological testing, date and results):*

_____

_____

_____

_____

D. Describe how proposed testing will impact future psychological treatment:

_____

_____

_____

_____

E. List test(s) planned and time required. *(note: time required for each test should include administration, scoring and interpretation and brief write-up. Valueoptions does not reimburse for lengthy reports; see Provider Manual for "Sample Psychological Testing Evaluation Form")*

Specific Test Planned	**Hours required**
Total Time Required:	

Note: See *ValueOptions* Provider Manual for complete testing guidelines/criteria. Following are two guidelines that have frequent relevance:

1. Testing that is primarily for educational purposes **is** not a covered benefit. (This disqualifier may be subject to account specific arrangements.)
2. Extended testing for ADHD is not authorized prior to a thorough evaluation with rating scales. (Providers should usually first seek approval for a 90801 and a 90806 for rating scale review and feedback before requesting further ADHD testing. Provide clear explanation in Section C above why initial evaluation was insufficient to answer the ADHD referral questions.)

_____ _____

Signature of Psychologist/Tester Date

EXHIBIT C

COMPLAINTS & GRIEVANCES PROCESS

VaZueOptions offers a complaint and grievance resolution process, which includes a two-level grievance appeal process. The complaint process is initiated by using the following procedure:

1) You or your representative will communicate your complaint in writing or telephonically to a *ValueOptions* representative by calling *ValueOptions* at **800-236-0756.**

2) A *VaZueOptions* representative will attempt to resolve your complaint at the time of your call. In the event that a complaint cannot be answered at the first point of contact, and needs to be forwarded to another individual for follow up, the status of your complaint remains open until a final determination is made. An acknowledgement letter will be sent to you or your representative acknowledging your written/telephonic complaint within five (5) business days of *ValueOptions* receiving it. *VaZueOptions* makes every effort to provide an outcome of determination or resolution of your complaint in a timely matter and is in accordance with the claim filing limitations.

3) Once a determination regarding your written/telephonic complaint has been made, a resolution letter is sent to you or your representative. You will be advised of the right to appeal or grieve *VaZueOptions'* determination and will be provided with the necessary information for completing your grievance of the determination.

The appeal process is initiated by using the following procedure:

4) If you are not satisfied with the outcome of the determination or resolution of your complaint, you may request an Appeal of the determination within 60 days of the date of *ValueOptions'* determination. You may file this appeal of your grievance in writing and send to the **home county** of the beneficiary (child).

EXHIBIT D

See attached Trend Report Example

ASO Trend Information

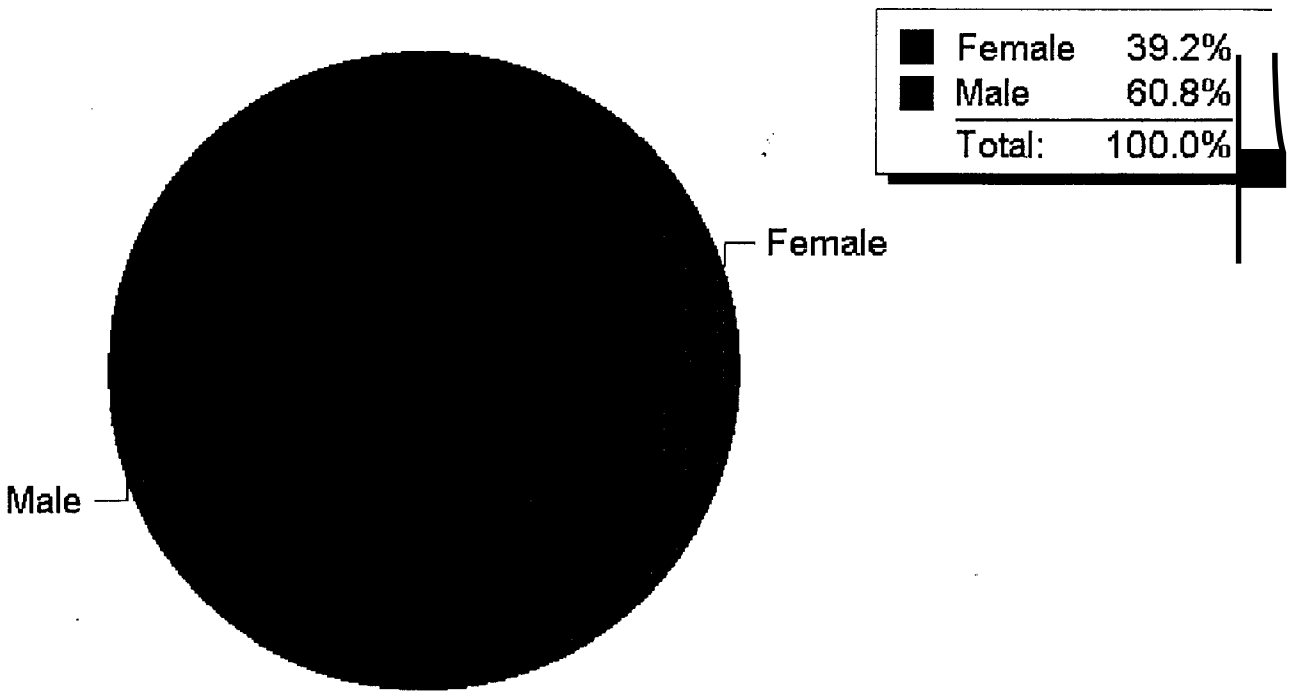
7-1-03 through 12-31-03

- Total # of Services
  - 24,066
- Number of Children Served
  - 3,235
- Average Number of Services per Child
  - 7.44
- # of Kids Receiving Meds
  - 844/26%

Report Title	**CMHDA ASO Child Characteristics: Gender Distribution**				
Client Name	**CMHDA**				
Report Period	**From**	07/01/03	**to**	12/31/03	

Report Description/Data Source

A Chart that summerizes utilization by Gender.
Tables: rpt_claim_lb

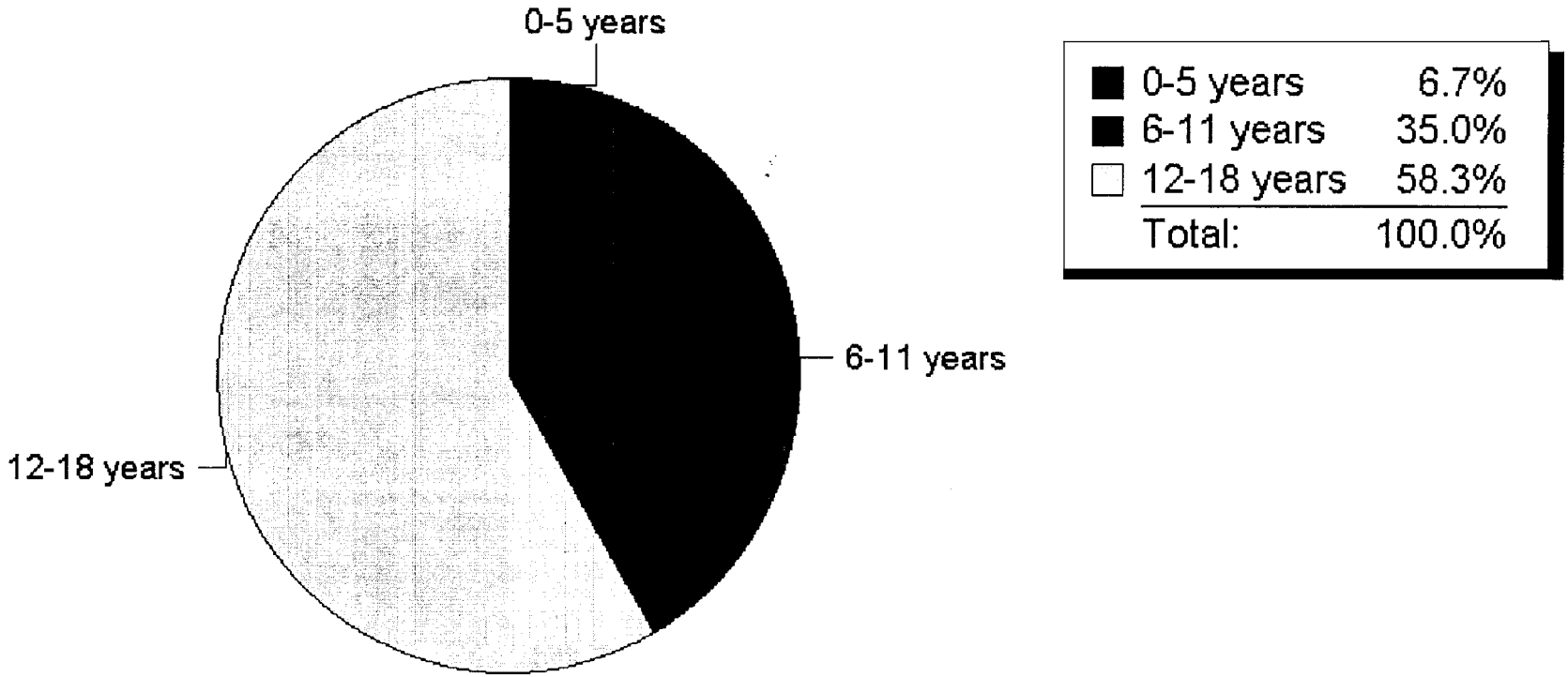


Report Title	**CMHDA ASO Child Characteristics: Age Distribution**
Client Name	**CMHDA**
Report Period	**From** 07/01/03 **to** 12/31/03

Report Description/Data Source

A Chart that summerizes utilization by Age.
Tables: rpt_claim_lb

22
22



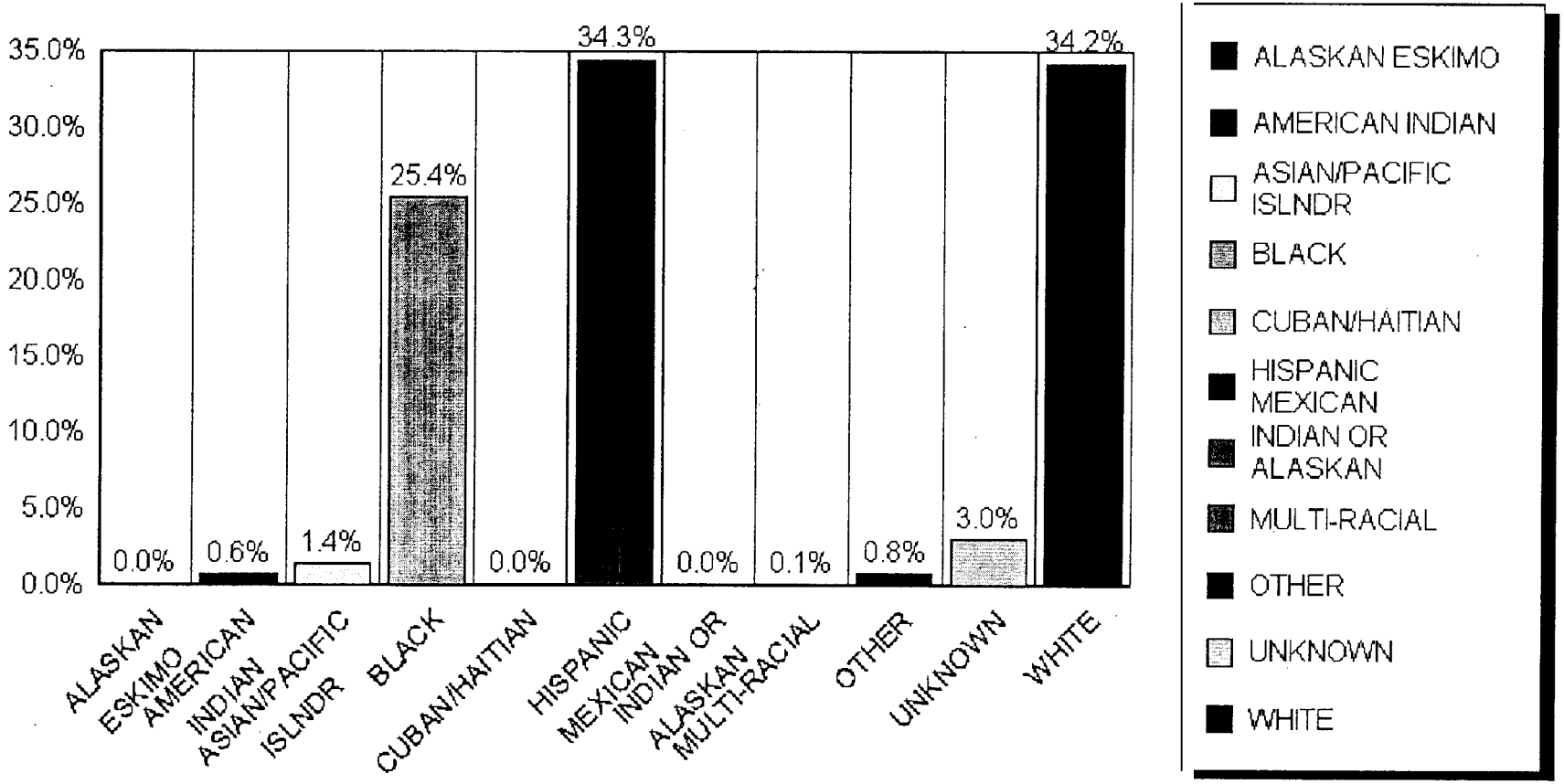
Report Title ASO Ethnicity Mix (Based on claims data)

Client Name CMHD

Report Period From 07/01/03 to 12/31/03

Report Description/Data Source

A Chart that summarizes utilization by Ethnicity.
Tables: rpt_claim_lb



Report Title ASO Living Arrangements

Client Name CMHDA

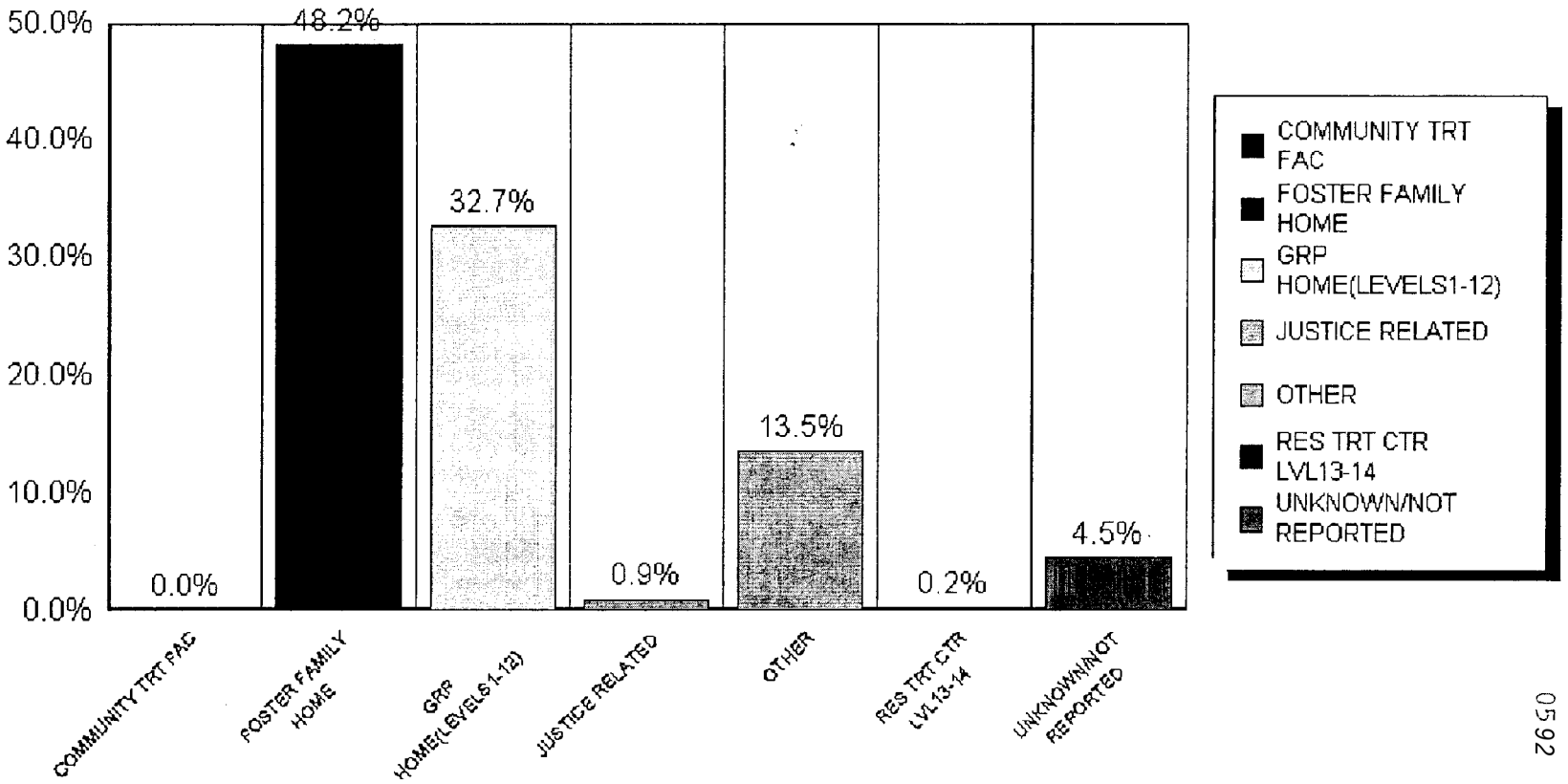
Report Period From 07/01/03 to 12/31/03

Report Description/Data Source

This report shows the living arrangement of members

Data source: CMHD_livarr

22
27



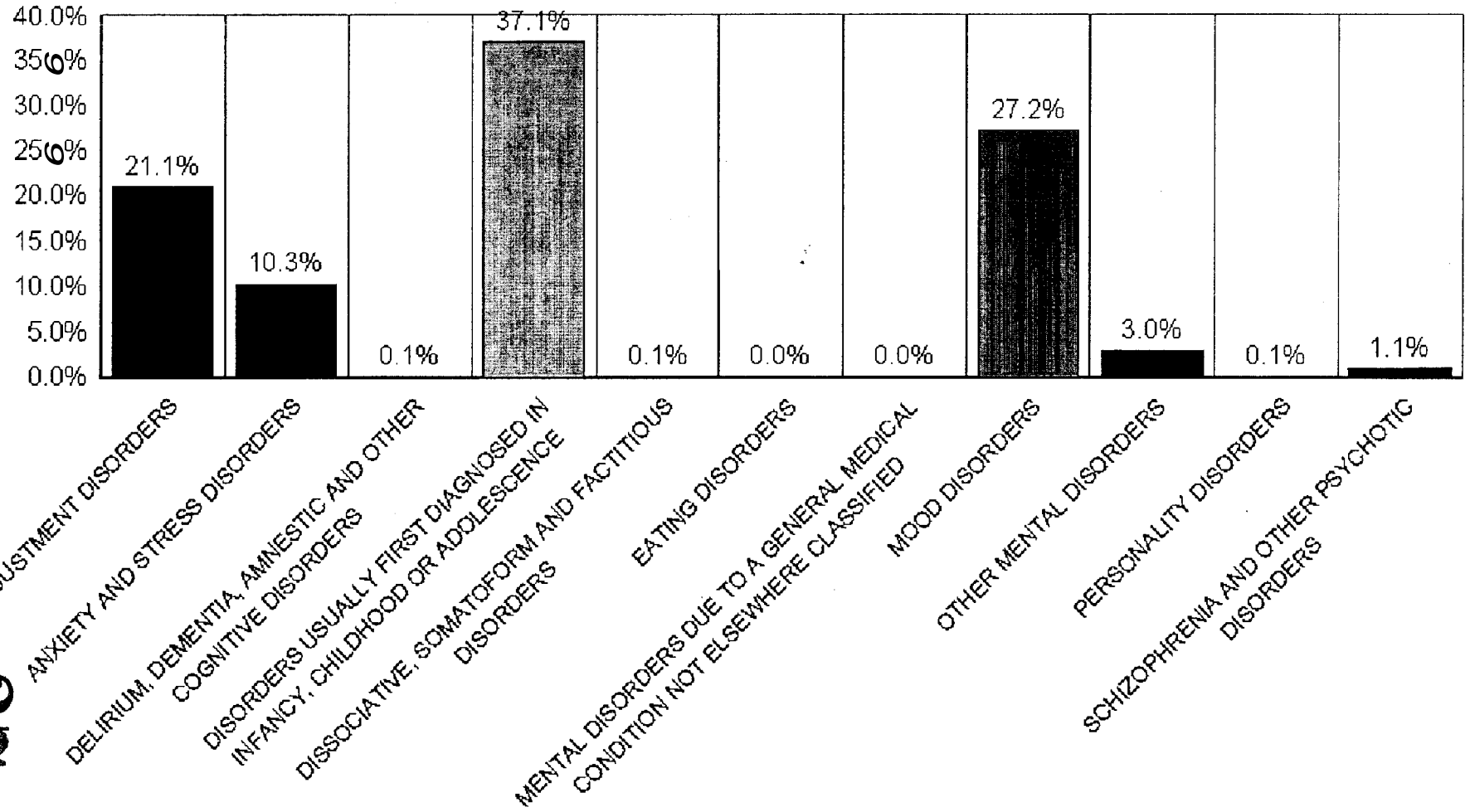
0592

Report Title ASO Diagnoses Trend Data

Client Name CMHDA

Period From 07/01/03 to 12/31/03

Report Description/Data Source
A graph that summarizes diagnoses trend.
Tables: CMHD_diag_trend

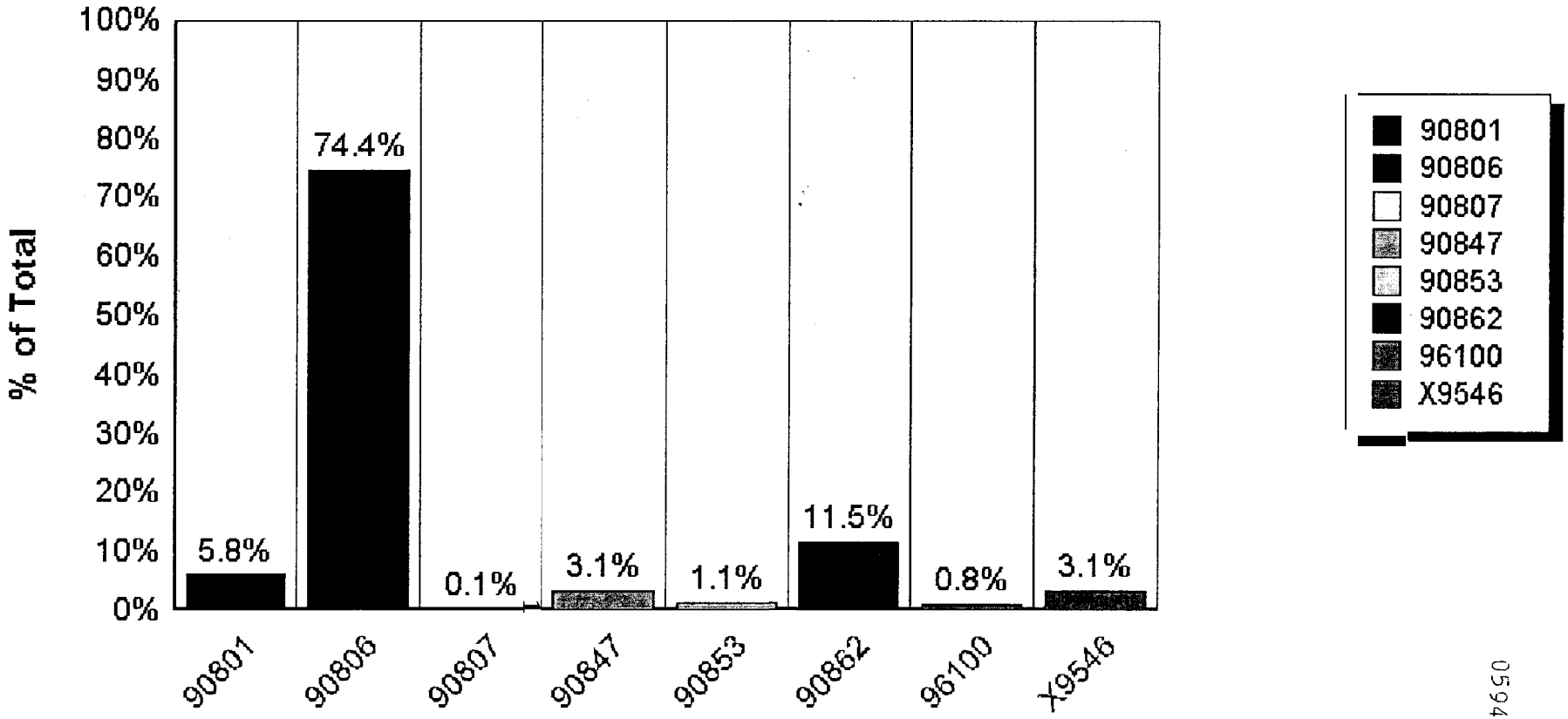


Report Title	**CPT Code (based on services)**
Client Name	**CMHDA**
Report Period	**From** 07/01/03 **to** 12/31/03

Report Description/Data Source

A Chart that summerizes utilization by CPT Code.
Tables: rpt_claim_lb

22



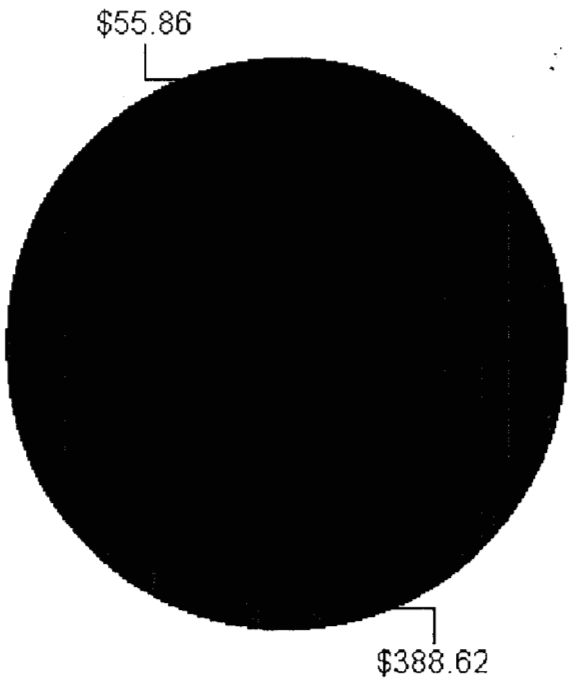
0594

Report Title	**ASO Cost Data Per Transaction Per Child**				
Client N	**CMHDA**				
Report Period	**From**	07/01/03	**to**	12/31/03	

Report Description/Data Source

A table which compares Cost per Service and Cost per Member.

Source: CMHD_trans_cost



Pay Per Member	87.4%
Pay per Service	12.6%
Total:	100.0%

EXHIBIT E

Tier 1

Valueoptions Medi-Cal Reimbursement Schedule

Maximum Allowable for Professional Services; Effective: 7/1/2004

CPT	Description	Licensed Psychiatrist	Licensed Professional Therapist
90801	Psychiatric diagnostic interview examination	$85.00	$45.00
90806 **90807**	Individual psychotherapy, in an office or outpatient facility, approx. 45-50 minutes	$35.00	$35.00
90847	Family psychotherapy (conjoint)	$35.00	$35.00
90853	Group psychotherapy	$12.00	$12.00
90862	Pharmacologic management	$45.00	n/a*
X9546	Case Conference	$35.00	$35.00
96100	Psychological testing, with interpretation and report, per hour	*$35.00*	$35.00

Tier 1 Counties

Sonoma County
Marin County
Tuolumne County
Butte County
Plumas County
Del Norte County
Kings County
Contra Costa County
Sutter-Yuba County
Imperial County
Lassen County
Siskiyou County
Napa County

27

Tier 2

ValueOptions Medi-Cal Reimbursement Schedule

Maximum Allowable for Professional Services; Effective: 7/1/2004

CPT	Description	Licensed Psychiatrist	Licensed Professional Therapist
90801	Psychiatric diagnostic interview examination	$85.00	$55.00
90806 **90807**	Individual psychotherapy, in an office or outpatient facility, approx. 45-50 minutes	$45.00	$45.00
90847	Family psychotherapy (conjoint)	$45.00	$45.00
90853	Group psychotherapy	$15.00	$15.00
90862	Pharmacologic management	$45.00	n/a*
X9546	Case Conference	$45.00	$45.00
96100	Psychological testing, with interpretation and report, per hour	$45.00	$45.00

Tier 2 Counties

Santa Clara County
Amador County
Mariposa County
Stanislaus County
Yolo County
Merced County
San Joaquin County
Los Angeles County
Orange County
Glenn County
Mendocino County
Nevada County
Tehama County
Calaveras County
El Dorado County
Humboldt County
San Mateo County
Fresno County
Sacramento County
Madera County
Inyo County
Placer County
Kern County
Santa Barbara County
Alameda County
Lake County
Modoc County
Shasta County
Colusa County
Trinity County
Santa Cruz County
Sierra

27

Tier 3

ValueOptions Medi-Cal Reimbursement Schedule

Maximum Allowable for Professional Services; Effective: 7/1/2004

CPT	Description	Licensed Psychiatrist	Licensed Professional Therapist
90801	Psychiatric diagnostic interview examination	$85.00	*$65.00*
90806 **90807**	Individual psychotherapy, in an office or outpatient facility, approx. **45-50** minutes	*$55.00*	*$55.00*
90847	Family psychotherapy (conjoint)	*$55.00*	*$55.00*
90853	Group psychotherapy	$20.00	$20.00
90862	Pharmacology management	**$45.00**	n/a*
X9546	Case Conference	*$55.00*	$55.00
96100	Psychological testing, with interpretation and report, per hour	$55.00	$55.00

Tier 3 Counties

Monterey County
Solano County
Mono County
Tulare County
San Bernardino County
Ventura County
San Benito County
San Francisco County
Alpine County
Riverside County
San Luis Obispo County

Tier 4

ValueOptions Medi-Cal Reimbursement Schedule

Maximum Allowable for Professional Services; Effective: 7/1/2004

CPT	Description	Licensed Psychiatrist	Licensed Professional Therapist
90801	Psychiatric diagnostic interview examination	$85.00	$75.00
90806 **90807**	Individual psychotherapy, in an office or outpatient facility, approx. 45-50 minutes	$65.00	$65.00
90847	Family psychotherapy (conjoint)	$65.00	$65.00
90853	Group psychotherapy	$30.00	*$30.00*
90862	Pharmacologic management	$45.00	n/a*
X9546	Case Conference	$65.00	$65.00
96100	Psychological testing, with interpretation and report, per hour	$65.00	$65.00

Tier 4 Counties

San Diego County

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EXHIBIT F 0600

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Health Insurance Portability & Accountability Act Business Associate Agreement ("HIPAA Agreement") by and between the California Counties Medi-Cal Out-of-County Care Program for the County of Santa Cruz ("County") and Value Options, Inc. ("Business Associate"), is effective as of the compliance date of the Privacy Rule (defined below) (the "Agreement Effective Date").

RECITALS

A. The parties have entered into a services agreement ("Services Agreement") setting forth the duties and responsibilities of the parties relating to administration of various health plans. That Services Agreement contains certain commitments by the parties to safeguard the confidentiality of data. The parties wish to supplement those commitments to satisfy the requirements of current law.

B. The parties wish to disclose certain information to each other pursuant to the terms of this HIPAA Agreement and the Services Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

C. County and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to the other pursuant to this HIPAA Agreement and the Services Agreement, and to comply with applicable transaction and code requirements in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HHS") (collectively "HIPAA") and other applicable federal and state laws.

D. The parties acknowledge that certain federal or state laws may take precedence over HIPAA. The parties agree that this HIPAA Agreement, the operational requirements hereunder, and the Services Agreement shall be interpreted to enable the parties to comply with any or all of HIPAA, the Privacy Rule (defined below), federal or applicable state laws.

In consideration of the mutual promises below and the exchange of information pursuant to this HIPAA Agreement and the Services Agreement, the parties agree as follows:

1. Definitions.

a. "Covered Entity" means (1) a health plan; **(2)** a health care clearinghouse; **(3)** a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA.

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b. "Designated Record Set" or "DRS" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

c. "HHS Transaction Standards Regulation" shall mean 45 CFR Sections 160 and 162.

d. "Information" shall mean any "health information" as defined in 45 CFR Section 160.102.

e. "Individual" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.502(g).

f. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

g. "Protected Health Information" or "PHI" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501, and is the information created or received by Business Associate from or on behalf of County.

h. "Required by Law" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

i. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or designee.

2. Permitted Uses and Disclosures of PHI. Except as otherwise limited in this HIPAA Agreement or by law, Business Associate may: (i) use or disclose Protected Health Information to perform functions, activities or services for, or on behalf of, County as specified in the Services Agreement between the parties and this HIPAA Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by a Covered Entity; (ii) use Protected Health Information to carry out the legal responsibilities of Business Associate; (iii) conduct any other use or disclosure permitted or required by HIPAA or applicable federal or state law; and (iv) use Protected Health Information for the proper management and administration of Business Associate.

3. Obligations of Business Associate.

a. Appropriate Safeguards. Business Associate shall use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this HIPAA Agreement or Required by Law.

b. Reporting of Improper Use or Disclosure. Business Associate shall report to

County any use or disclosure of Protected Health Information not provided for by this HIPAA Agreement promptly upon becoming aware of such use or disclosure. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its agents or subcontractors in violation of the requirements of HIPAA or this HIPAA Agreement.

c. Business Associate's Agents. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides Protected Health Information agrees to the same restrictions and conditions that apply through this HIPAA Agreement to Business Associate with respect to such Protected Health Information.

d. Access to PHI. Business Associate shall provide access, at the request of the Individual, and in the time and manner Required by Law, to Protected Health Information in a Designated Record Set in order to meet the requirements under 45 CFR Section 164.524.

Any denial of access to Protected Health Information determined by Business Associate shall be the responsibility of Business Associate, including, but not limited to, resolution or reporting of all appeals and/or complaints arising therefrom.

e. Amendment of PHI. Business Associate shall make a determination on any authorized request by an Individual for amendment(s) to Protected Health Information in a Designated Record Set in the time and manner Required by Law and in accordance with the requirements under 45 CFR Section 164.526.

Any denial of amendment of Protected Health Information determined by Business Associate shall be the responsibility of Business Associate, including, but not limited to, resolution or reporting of all appeals and/or complaints arising therefrom.

Business Associate shall report all approved amendments or statements of disagreement/rebuttals in accordance with 45 CFR Section 164.526.

Within ten (10) business days of receipt of a request from County to amend an Individual's PHI in the DRS, Business Associate shall incorporate any such approved amendment, statements of disagreement and/or rebuttals into its DRS as required by 45 CFR Section 164.526.

f. Documentation of Disclosures. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for a Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR Section 164.528. At a minimum, such documentation shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Health Information and, if known, the address of the entity or person; (iii) a brief description of the Protected Health Information disclosed; and

(iv) a brief statement of the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure, or a copy of the Individual's authorization, or a copy of the written request for disclosure.

g. Accounting of Disclosures. Business Associate agrees to provide to an Individual, in the time and manner Required by Law, information collected in accordance with Section 3(f) of this HIE'AA Agreement, to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR Section 164.528.

h. Governmental Access to Records. Business Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of County, available to County or, at the request of County, to the Secretary for purposes of the Secretary determining County's compliance with the Privacy Rule.

1. HHS Transaction Standards Regulation. If Business Associate conducts in whole or part standard transactions for or on behalf of County, Business Associate will comply, and will require any subcontractor or agent involved with the conduct of such standard transactions to comply, with the HHS Standard Transaction Regulation. Business Associate will not enter into, or permit its subcontractors or agents to enter into, any agreement in connection with the conduct of standard transactions for or on behalf of County that:

(i) Changes the definition, data condition, or use of a data element or segment in a standard transaction;

(ii) Adds any data elements or segments to the maximum defined data set;

(iii) Uses any code or data element that is marked "not used" in the standard transaction's implementation specification or is not in the standard transaction's implementation specification; or

(iv) Changes the meaning or intent of the standard transaction's implementation specification.

j. Business Associate agrees to conduct electronically the HIPAA standard transactions, as well as any non-standard transactions, with or on behalf of County as set out in Exhibit X.

4. Obligations of County

a. Delegation to Business Associate. As set forth in Sections 3(d), 3(e) and 3(g) of this HIPAA Agreement, County hereby delegates to Business Associate the County's responsibility to provide access, amendment, and accounting rights to Individuals with respect to Protected Health Information in the DRS in Business Associate's possession. It is understood that Business Associate will interact with the Individual

directly, up to and including resolution of any appeals or reporting of complaints under HIPAA or applicable federal or state law.

b. Responsibility for Further Disclosures. County shall be responsible for ensuring that any further disclosure by County of Protected Health Information (including, but not limited to, disclosures to employers, plan sponsors, agents, vendors, and group health plans) complies with the requirements of **HIPAA** and applicable federal and state law.

c. Notice of Privacy Practices. County shall provide Business Associate with the notice of privacy practices that County produces in accordance with **45** CFR Section 164.520, as well as any changes to such notice. Business Associate shall not distribute its own notice to Individuals. Business Associate will provide input to County as to the accuracy and completeness of its Notice with regard to Specialty Mental Health provisions. Business Associate shall not be responsible for the content of the Notice nor any errors or omissions from the Notice.

d. Changes in Permission by Individual. County shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.

e. Restrictions on PHI. County shall notify Business Associate of any restriction upon the use or disclosure of Protected Health Information that County has agreed to in accordance with 45 CFR Section 164.522 if such changes affect Business Associate's permitted or required uses and disclosures.

f. Permissible Requests by County. County shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by County, except for Business Associate's use of PHI for its proper management and administration in accordance with Section 2 of this HIPAA Agreement.

g. Disclosure to Third Parties. County may request that Business Associate disclose PHI directly to another party. County agrees that all such disclosures requested by County shall be for purposes of County's treatment, payment or health care operations.

5. Indemnification

County and Business Associate agree to indemnify and hold each other harmless from any and all liability, damages, costs (including reasonable attorneys' fees and costs) and expenses

imposed upon or asserted against the non-indemnifying party arising out of any claims, demands, awards, settlements or judgments relating to the indemnifying party's, or its director's, officer's, employee's, contractor's, business associate's, trading partner's, client employer's, client plan sponsor's, and/or client employer health plan's use or disclosure of PHI contrary to the provisions of this HIPAA Agreement or applicable law.

6. Term and Termination.

a. Term. The term of this HIPAA Agreement shall commence as of the Agreement Effective Date, and shall terminate when all of the Protected Health Information provided by either party to the other, or created or received by Business Associate on behalf of County, is destroyed or returned to County or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with Subsection c. of this Section.

b. Termination for Cause. Upon either party's knowledge of a pattern of activity or a practice that constitutes a material breach of this HIPAA Agreement, the non-breaching party shall provide a written notice of the breach and an opportunity to the other party to cure the breach or end the violation within the time specified in the notice, in accordance with the for-cause termination provisions of the Services Agreement. If termination is not feasible, the non-breaching party may report the problem to the Secretary.

c. Effect of Termination.

(i) Except as provided in paragraph (ii) of this Section 6(c), upon termination of this HIPAA Agreement and the Services Agreement for any reason, Business Associate shall return or destroy all Protected Health Information received from County, or created or received by Business Associate on behalf of County. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(ii) The parties recognize that Business Associate may be required to retain **PHI** to fulfill certain contractual or regulatory requirements, making return or destruction infeasible. Business Associate shall extend the protections of this HIPAA Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

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7. References. A reference in this HIPAA Agreement to HIPAA means the law or regulation as in effect on the Agreement Effective Date or as subsequently amended, and for which compliance is required.

8. Amendment. The parties agree to take such action as is necessary to amend this HIPAA Agreement from time to time as is required for County to comply with the requirements of HIPAA.

9. Survival. The respective rights and obligations of Business Associate under Sections 5 and 6(c) of this HIPAA Agreement shall survive the termination of this HIPAA Agreement and the underlying Services Agreement.

10. No Third Party Beneficiaries. Nothing express or implied in this HIPAA Agreement is intended to confer, nor shall anything herein confer upon any person, other than County, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

11. Effect on Agreement. Except as specifically required to implement the purposes of this HIPAA Agreement, or to the extent inconsistent with this HIPAA Agreement, all other terms of the underlying Services Agreement shall remain in force and effect.

12. Interpretation. The provisions of this HIPAA Agreement shall prevail over any provisions in the underlying Services Agreement, or any operational activities under the Services Agreement, which conflicts or is inconsistent with any provision in this HIPAA Agreement. Any ambiguity in this HIPAA Agreement, the Services Agreement or in operations shall be resolved in favor of a meaning that permits County or Business Associate to comply with the Privacy Rule or the applicable federal or state rule.

IN WITNESS WHEREOF, the parties hereto have duly executed this HIPAA Agreement as of the Agreement Effective Date.

COUNTY	VALUEOPTIONS, INC.
Santa Cruz	
By:	By:
Print Name: RAMA KHALSA	Print Name: Julie Larson
Title: HSA DIRECTOR	Title: Vice President
Date: 6-15-04	Date: 6/22/04

EXHIBIT G

COUNTY CONTRACT MAXIMUM

NO FIXED MAXIMUM AMOUNT

0609

COUNTY OF SANTA CRUZ
REQUEST FOR APPROVAL OF AGREEMENT

TO. Board of Supervisors
County Administrative Office
Auditor Controller

FROM: **Health Services Agency** (Department)

BY: _____ (Signature) 5/20/4 (Date)
Signature certifies that appropriations/revenues are available

AGREEMENT TYPE (Check One) Expenditure Agreement [X] Revenue Agreement [ ]

The Board *of* Supervisors is hereby requested to approve the attached agreement and authorize the execution of same.

1. Said agreement is between the **Health Services Agency - Mental Health** (Department/Agency)

and **JC Nationwide, 5284 S Commerce Dr, Suite C-294, Murray, UT, 84107** (NamelAddress)

2. The agreement will provide **temporary psychiatric services during psychiatrist recruitments**

3. Period of the agreement is from **June 1, 2004** to **June 30,2005**

4. Anticipated Cost Is $**112 per hour** [ ] Fixed [ ] Monthly Rate [ ] Annual Rate [ ] Not to Exceed

Remarks: **Auditor - encumber $1,000**

5. Detail: [ ] On Continuing Agreements List for FY - Page CC- _____ Contract, No: 43195 OR [ ] 1st Time Agreement
33215 W9 required
[ ] Section II No Board letter required, will be listed under Item 8
[ ] Section III Board letter required
[ ] Section IV Revenue Agreement

6. Appropriations/Revenues are available and are budgeted in **363141** (Index) **3647** (Sub object)

T - IF APPROPRIATIONS ARE INSUFFICIENT. ATTACHED COMPLETED AUD-74 OR AUDBO

Appropriations (are) / are not available and (have been) / will be encumbered.

Contract No: 43195 33215

By: _____ Auditor-Controller Deputy Date: 6/3/04

Proposal and accounting detail reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize

Health Services Agency Director (Dept/Agency Head) to execute on behalf of the _____

Health Services Agency (Department/Agency)

Date: _____

By: _____ County Administrative Offi e

Distribution:
Board of Supervisors - White
Auditor Controller - Canary
Auditor-Controller - Pink
Department - Gold

ADM - 29 (8101)
Title I, Section 300 Proc Man

State of California
County of Santa Cruz
I, Susan A. Mauriello ex-officio Clerk of the Board of Supervisors of the County *of* Santa Cruz, State of California, do hereby certify that the foregoing request for approval of agreement was approved by said Board of Supervisors as recommended by the County Administrative Office by order duly entered in the minutes of said Board on June 15 4

By: Deputy Clerk

AUDITOR-CONTROLLER USE ONLY

CO _____ $ _____

Document No. JE Amount Lines H/TL Keyed By Date

TC1 _____ $ _____ /

cription Amount Index Sub object User Code

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Contract No. TBD

The COUNTY OF SANTA CRUZ through the
HEALTH SERVICES AGENCY – Mental Health and Substance Abuse Services 0610
1400 Emeline Ave., P.O. **Box** 962, Santa Cruz CA 95061-0962

hereinafter called COUNTY and:

JC Nationwide
5284 S Commerce Drive, Suite C - 294
Murray, Utah 84107
Phone: (800) 809-9990

hereinafter called CONTRACTOR for: providing COUNTY with locum tenens Psychiatrists.

WHEREAS CONTRACTOR possesses certain **skills,** experience, education and competency to perform the special services and, COUNTY desires to engage CONTRACTOR for such special services upon the terms provided; and

WHEREAS pursuant to the provisions **of** California Government Code, Section 31000, the BOARD OF SUPERVISORS of COUNTY is authorized to enter into an agreement for such services.

NOW, THEREFORE, the parties hereto do mutually agree as set forth in:

EXHIBIT	TITLE
A	Duties and Compensation
B	Personal Services Provisions
H_2	Not Included in this Agreement

Said exhibits attached hereto are incorporated into this Agreement by this reference.

IN WITNESS THEREOF, COUNTY AND CONTRACTOR have executed this Agreement to be effective:

June
~~March 1~~, 2004 through June 30, 2005

CONTRACTOR

Joseph Schofield
~~Sr. Account Executive~~ Director - Psychiatry

COUNTY

HEALTH SERVICES AGENCY

* Changes made: item 3.(1)(b) deleted the word "owned". item 3.(2)(c) deleted in its entirety. and item 3.(2)(b) deleted the word "endorsed". 1-27-04

Approved as to Form:

County Counsel 11/3/04

Standard Insurance Requirements ☐
Certain Insurance Provisions Waived ☐

Risk Management 1-9-04

Suffix: 01

Index: 363141
Subobject: 3647
Amount: $112 per hour

Total Contract Amount: N/A

Distribution:
Clerk of the Board
Auditor-Controller
Health Services Agency
Mental Health and Substance Abuse Services
Contractor

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COUNTY OF SANTA CRUZ

EXHIBIT A - DUTIES AND COMPENSATION

1. DUTIES. Provide the COUNTY's Health Service Agency with qualified locum tenens Psychiatrist(s) for the purpose of meeting the medical staffing needs **of** the Mental Health Division. CONTRACTOR's duties further delineated in Attachment A

2. COMPENSATION. In consideration for CONTRACTOR accomplishing said result, COUNTY agrees to pay CONTRACTOR a rate of $1**12.00** per hour. Compensation includes any and all reimbursement due to the CONTRACTOR for duties performed, including reimbursement for all per diem costs and all transportation costs necessary to accomplish the result contracted for.

EXHIBIT B, 2004-2005

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COUNTY OF SANTA CRUZ

EXHIBIT B - PERSONAL SERVICES PROVISIONS

1. EARLY TERMINATION. Either party hereto may terminate this contract at any time by giving thirty (30) days written notice to the other party.

2. INDEMNIFICATION FOR DAMAGES. TAXES AND CONTRIBUTIONS. CONTRACTOR shall exonerate, indemnify, defend, and hold harmless COUNTY (which shall include, without limitation, its officers, agents, employees and volunteers) from and against:

a) Any and all claims, demands, losses, damages, defense costs, or liability of any kind or nature which COUNTY may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, arising out of, or in any manner connected with the CONTRACTOR'S performance under the terms of this contract, including but not limited to the use, misuse, or failure of any equipment, materials, tools, supplies or other property furnished to CONTRACTOR by COUNTY, excepting any liability arising out of sole negligence of the COUNTY. Such indemnification includes any damage to the person(s) or property(ies) of CONTRACTOR and third persons.

b) Any and all Federal, State and Local taxes, charges, fees, or contributions required to be paid with respect to CONTRACTOR and CONTRACTOR'S officers, employees and agents engaged in the performance of this Contract (including, without limitation, unemployment insurance, social security and payroll tax withholding).

c) Any claim for compensation made against COUNTY by a psychiatrist provided by CONTRACTOR alleging that the services performed by the psychiatrist under this Agreement were performed as an employee of COUNTY.

3. INSURANCE.

CONTRACTOR, at its sole cost and expense, for the full term of this Contract (and any extensions thereof), shall obtain and maintain professional liability for each subcontractor as set forth in Paragraph 3 (1)(d) below. Such insurance coverage shall be primary coverage as respects COUNTY and any insurance or self-insurance maintained by COUNTY shall be excess of CONTRACTORS insurance coverage and shall not contribute to it. In addition, CONTRACTOR shall be responsible for providing evidence to COUNTY that each subcontractor maintains the insurance set forth in Paragraphs 3(1)(a), 3 (1)(b), and 3 (1)(c). CONTRACTOR shall provide evidence of insurance coverage for each subcontractor as follows:

(1) Types of Insurance and Minimum Limits

(a) CONTRACTOR shall maintain Worker's Compensation in the minimum statutorily required coverage amounts. This insurance coverage shall not be required if CONTRACTOR has no employees.

(b) CONTRACTOR shall maintain Automobile Liability Insurance for any vehicle used in the performance of this Agreement, including ~~owned~~, non-owned (e.g., owned by CONTRACTORS employees), leased or hired vehicles, in the minimum amount of $500,000 combined single limit per occurrence for bodily injury and property damage.

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(c) CONTRACTOR shall maintain Comprehensive or Commercial General Liability Insurance coverage in the minimum amount of $1,000,000 combined single limit, including coverage for: a) bodily injury, b) personal injury, c) broad form property damage, d) contractual liability, and e) cross-liability.

(d) CONTRACTOR shall maintain Professional Liability Insurance in the minimum amount of **$1,000,000** combined single limit for Psychiatrist acts and omissions, and services performed under this Agreement.

(2) Other Insurance Provisions

(a) If any insurance coverage required in this Agreement is provided on a "Claims Made" rather than "Occurrence" form, CONTRACTOR agrees to maintain the required coverage for a period of three **(3)** years after the expiration of this Agreement (hereinafter "post agreement coverage") and any extensions thereof and CONTRACTOR agrees to require that each subcontractor adhere to the same requirement. CONTRACTOR and any subcontractors may maintain the required post agreement coverage by renewal or purchase of prior acts **or** tail coverage. This provision **is** contingent upon post agreement being both available and reasonably affordable in relation to the coverage provided during the term of this Agreement. For purposes of interpreting this requirement, a cost not exceeding **100%** of the last annual policy premium during the term ***of*** this Agreement in order to purchase prior acts **or** tail coverage for post agreement coverage shall be deemed to be reasonable.

(b) All required Comprehensive or Commercial General Liability Insurance shall **be** ~~endorsed~~ to contain the following clause:

"The County of Santa Cruz, **its** officials, employees, agents and volunteers are added as an additional insured as respects the operations and activities of, **or** on behalf of, the named insured performed under Agreement **with** the County of Santa Cruz".

~~(c) All required insurance policies shall be endorsed to contain the following clause:~~

~~"This insurance shall not be canceled until after thirty (30) days prior written notice has been given to: Claims Desk, Health Services Administration, P.O. Box 962, Santa Cruz, CA 95061.~~

(d) CONTRACTOR agrees to provide **its** insurance broker(s) as well as the insurance broker for each subcontractor with a full copy of these insurance provisions and provide COUNTY within **10** days of the effective date of this Agreement with Certificates **of** Insurance for all required coverage, All Certificates of Insurance shall be delivered or sent to Claims Desk, Health Services Administration, **P.O. Box 962,** Santa Cruz, CA **95061.**

4. **EQUAL** EMPLOYMENT OPPORTUNITY. During and in relation to the performance of this Agreement, CONTRACTOR agrees as follows:

a. CONTRACTOR shall not discriminate against any employee or applicant for employment because of race, color, creed, religion, national origin, ancestry, disability, medical condition (cancer related and genetic characteristics), marital status, sex, sexual orientation, age (over 18), veteran status, gender, pregnancy, or any other nonmerit factor unrelated to job duties. Such action shall include, but not be limited to, the following: recruitment; advertising; layoff or termination; rates of pay or other forms of compensation;

and selection for training (including apprenticeship), employment, upgrading, demotion, or transfer. The CONTRACTOR agrees to post in conspicuous places, available to employees and applicants for employment, notice setting forth the provisions of this non-discrimination clause.

b. If this Agreement provides compensation in excess of $50,000 to CONTRACTOR and if CONTRACTOR employs fifteen **(15)** or more employees, the following requirements shall apply:

(1) The CONTRACTOR shall, in all solicitations or advertisements 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, creed, religion, national origin, ancestry, disability, medical condition (cancer related and genetic characteristics), marital status, sex, sexual orientation, age (over **18)**, veteran status, gender, pregnancy, or any other non-merit factor unrelated to job duties. In addition, the CONTRACTOR shall make a good faith effort to consider Minority/Women/Disabled Owned Business Enterprises in CONTRACTOR'S solicitation of goods and services. Definitions for Minority/Women/Disabled Owned Business Enterprises are available from the COUNTY General Services Purchasing Division.

(2) The CONTRACTOR shall furnish COUNTY Equal Employment Opportunity Office information and reports in the prescribed reporting format (PER **4012)** identifying the sex, race, physical or mental disability, and **job** classification of its employees and the names, dates and methods of advertisement and direct solicitation efforts made to subcontract with Minority/Women/Disabled Business Enterprises.

(3) In the event of the CONTRACTORS non-compliancewith the non-discrimination clauses of this Agreement or with any of the said rules, regulations, or orders said CONTRACTOR may be declared ineligible for further agreements with the COUNTY.

(4) The CONTRACTOR shall cause the foregoing provisions of this Subparagraph 13b. to be inserted in all subcontracts for any work covered under this Agreement by a subcontractor compensated more than **$50,000** and employing more than fifteen **(15)** employees, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

5. INDEPENDENT CONTRACTOR STATUS. CONTRACTOR and COUNTY have reviewed and considered the principal test and secondary factors below and agree that CONTRACTOR is an independent contractor and not an employee of COUNTY. CONTRACTOR **is** responsible for all insurance (workers compensation, unemployment, etc.) and all payroll related taxes. CONTRACTOR is not entitled to any employee benefits. COUNTY agrees that CONTRACTOR shall have the right to control the manner and means of accomplishing the result contracted for herein.

PRINCIPAL TEST: The CONTRACTOR rather than COUNTY has the right to control the manner and means of accomplishing the result contracted for.

SECONDARY FACTORS: (a) The extent of control which, by agreement, COUNTY may exercise over the details **of** the work is slight rather than substantial; (b) CONTRACTOR is engaged in a distinct occupation or business; (c) In the locality, the work to be done by CONTRACTOR is usually done by a specialist without supervision, rather than under the direction of an employer; (d) The skill required in the particular occupation is substantial

rather than stight; (e) The CONTRACTOR rather than the COUNTY supplies the instrumentalities, tools, and workplace; (9 The length of time for which CONTRACTOR is engaged is of limited duration rather than indefinite; (g) The method of payment of CONTRACTOR **is** by the job rather than by the time; (h) The work is part of a special or permissive activity, piogram, or project, rather than part of the regular business of COUNTY; (i) CONTRACTOR and COUNTY believe they are creating an independent contractor relationship rather than an employer-employee relationship; and (j) The COUNTY conducts public business. It is recognized that it is not necessary that all secondary factors support creation of an independent contractor relationship, but rather that overall there are significant secondary factors which indicate that CONTRACTOR is an independent contractor.

By their signatures to this Agreement, each **of** the undersigned certifies that it is his or her considered judgment that the CONTRACTOR engaged under this Agreement is, in fact, an independent contractor.

6. NONASSIGNMENT. CONTRACTOR shall not assign this Agreement without the prior written consent of the COUNTY.

7. RETENTION AND AUDIT OF RECORDS. CONTRACTOR shall retain records pertinent to this Agreement for a period of not less than five **(5)** years after final payment under this Agreement or until a final audit report is accepted by COUNTY, whichever occurs first. CONTRACTOR hereby agrees to be subject to the examination and audit by the Santa Cruz County Auditor-Controller, the Auditor General of the State of California, or the designee of either for a period of five **(5)** years after final payment under this Agreement.

8. PRESENTATION OF CLAIMS. Presentation and processing of any or all claims arising out of or related to this Agreement shall be made in accordance with the provisions contained in Chapter **1.05** of the Santa Cruz County Code, which by this reference is incorporated herein.

9. TRAVEL, **FOOD** AND LODGING EXPENSES. CONTRACTOR shall not make any additional claim for travel, food or lodging expenses related to this Agreement.

10. CONTRACTOR BILLING. CONTRACTOR shall bill COUNTY monthly for services provided by psychiatrists. Invoices shall be sent to Peter Spofford, Mental Health and Substance Abuse Services, P.O. Box **962,** Santa Cruz, CA **95061.**

11. ATTACHMENTS. This Agreement includes Attachment A, Additional Duties and Responsibilities.

12. HIPAA. CONTRACTOR agrees to obtain written assurance that any psychiatrist provided to COUNTY under this Agreement will comply with the Privacy Rule of the Health Insurance Portability and Accountability Act of **1996** (P.L. **104-191, 42** U.S.C. **1320d,** et seq., and regulations promulgated there under as amended from time to time (statute and regulations hereinafter referred to collectively as HIPAA).

Attachment A

COUNTY OF SANTA CRUZ
AND
JC Nationwide

Additional Duties and Responsibilities

CONTRACTOR shall:

1. Provide documentation of Psychiatrist(s) licensure and credentials.

2. Provide COUNTY with Psychiatrist(s) acceptable to COUNTY'S Mental Health Medical Director.

3. Reimburse Psychiatrist(s) directly.

4. Pay for Professional Liability (i.e., malpractice) insurance for any and all Psychiatrist(s) provided under this Agreement to COUNTY. This is in excess of any Professional Liability insurance maintained by Psychiatrist(s) or COUNTY and shall be considered primary coverage.

5. In addition to Professional Liability, meet all insurance requirements specified in Exhibit B, Paragraph 3 (1) a, b, c above.

6. As a highly trained professional, the Psychiatrist(s) placed by CONTRACTOR will perform professional services as an independent contractor(s). The Psychiatrist is not an employee of CONTRACTOR for any purpose. CONTRACTOR is interested in the final result of arranging coverage and not in making specific health care decisions. Because the Psychiatrist is not an employee, CONTRACTOR does not provide employee social security payments, workers' compensation insurance, unemployment insurance, or health insurance for the Psychiatrist(s).

CONTRACTOR and COUNTY agree:

1. This agreement will be governed by the laws of the State of California.