STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213 (Rev 06/03)

DHCS # 11-88374

FULLY EXECUTED

AGREEMENT NUMBER	REGISTRATION NUMBER
11-73028-000	ep 1238274

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

STATE AGENCY'S NAME
California Department of Mental Health AND California Department of Health Care Services

CONTRACTOR'S NAME
Monterey County Behavioral Health

2. The term of this Agreement is: April 1, 2012, through December 31, 2012

3. The maximum amount of this Agreement is: $31,208,974

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	Pages 3-7
Exhibit A1 – Service Delivery, Administrative and Operational Requirements	Pages 9-66
Exhibit B - Payment Provisions	Pages 67-73
Exhibit C* – General Terms and Conditions	GTC-610
Exhibit D – Special Provisions	Pages 75-79
Exhibit E – Additional Provisions	Pages 81-84
Exhibit F – HIPAA Business Associate Addendum	Pages 85-100
Attachment A – Business Associate Data Security Requirements	Pages 101-105

Items shown with an Asterisk (*), are hereby incorporated by reference and made part of this Agreement as if attached hereto.
These documents can be viewed at www.ols.dgs.ca.gov/Standard+Language

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.)*
County of Monterey

BY *(Authorized Signature)*
✍

DATE SIGNED *(Do not type)*
08/17/2012

PRINTED NAME AND TITLE OF PERSON SIGNING
Ray Bullick, Director of Health

ADDRESS
1270 Natividad Road
Salinas, CA 93906-3198

STATE OF CALIFORNIA

AGENCY NAME
See Page 2 for Official Signatures

BY *(Authorized Signature)*
✍

DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

ADDRESS

California Department of General Services Use Only

☒ Exempt per: WIC 14703

DMH USE ONLY

☐ State Master ☐ Contractor ☐ Contract Manager ☐ Accounting ☐ State Controller

California Department of Mental Health – Contract Number 11-73028-000

4/29/12

Kathryn Radtkey-Gaither, Chief Deputy Director — Date
1600 9th Street, Room 101, Sacramento, CA 95814

California Department of Health Care Services – Contract 11-88374

7-13-12

Jayna Querin, Chief, Contract Management Unit — Date
P.O. Box 997413, 1501 Capitol Avenue, Suite 71.5195, MS 1403
Sacramento, CA 95899-7413

Pursuant to the passage of AB 102, the California Department of Mental Health (DMH) will become the Department of State Hospitals on July 1, 2012. Welfare & Institutions Code, Sections 5775-5783 establish managed mental health care plans for the counties of California, administered by DMH. In accordance with the realignment of State Agency responsibility directed in AB 102 this function and many others currently performed by DMH will be transferred to the Department of Health Care Services (DHCS) effective July 1, 2012. This contract is established by DMH, but will be transferred to DHCS in accordance with this process. In order to facilitate a smooth transition, this Agreement is being issued as a three-party Agreement.

California Department of Mental Health – Contract Number 11-73028-000

Kathryn Radtkey-Gaither, Chief Deputy Director — Date
1600 9th Street, Room 101, Sacramento, CA 95814

California Department of Health Care Services

Jayna Querin, Chief, Contract Management Unit — Date
P.O. Box 997413, 1501 Capitol Avenue, Suite 71.5195, MS 1403
Sacramento, CA 95899-7413

Pursuant to the passage of AB 102, the California Department of Mental Health (DMH) will become the Department of State Hospitals on July 1, 2012. Welfare & Institutions Code, Sections 5775-5783 establish managed mental health care plans for the counties of California, administered by DMH. In accordance with the realignment of State Agency responsibility directed in AB 102 this function and many others currently performed by DMH will be transferred to the Department of Health Care Services (DHCS) effective July 1, 2012. This contract is established by DMH, but will be transferred to DHCS in accordance with this process. In order to facilitate a smooth transition, this Agreement is being issued as a three-party Agreement.

AKB AK
COW 8/10/12
RISK MANAGEMENT
COUNTY OF MONTEREY
APPROVED AS TO INDEMNITY/
INSURANCE LANGUAGE
By:
Date: 8/14/12

Reviewed as to fiscal provisions
Auditor-Controller
County of Monterey
8/10/12

TABLE OF CONTENTS

EXHIBIT A

1. Term of Contract.

April 1, 2012 – December 31, 2012

It is the intent of the parties that this contract remain in effect only until the earlier of the date that DHCS and the MHP execute a successor MHP contract or December 31, 2012, in accordance with paragraph 4.

2. Scope of Work.

A. The Contractor agrees to provide to the Department the services described herein: Provide or arrange for the provision of specialty mental health services to Medi-Cal beneficiaries of Monterey County within the scope of services defined in this contract.

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

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

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

Department

County Technical Assistance:

http://dmh.ca.gov/Services_and_Programs/Community_Programs/County_Technical_Assistance.asp

916-654-2147 (Phone)
916-654-5591 (Fax)

Contractor

Monterey County Behavioral Health
Wayne W. Clark, PhD, Behavioral Health Director
Phone: 831-755-4509
Fax: 831-755-4980

Direct all inquiries to:

Department

County Technical Assistance
1600 9th Street, Room 100
Sacramento, CA 95814

Contractor

Monterey County Behavioral Health
Wayne W. Clark, PhD, Behavioral Health Director
1270 Natividad Road
Salinas, CA 93906-3198

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

E. See Exhibits B, C, D, E, and F which are made part of this contract, for a detailed description of the work to be performed.

3. 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 California Department of Mental Health to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state; and Monterey County Behavioral Health agrees to operate the Mental Health Plan (MHP) for Monterey County. No provision of this contract is intended to obviate or waive any requirements of applicable law or regulation, in particular, the provisions noted above. In the event a provision of this contract is open to varying interpretations, the contract provision shall be interpreted in a manner that is consistent with applicable law and regulation.

4. Successor.

Effective July 1, 2012, the Department of Health Care Services (DHCS) shall assume the contract obligations specified in this contract on behalf of the state. On and after July 1, 2012, all references to the "Department" shall refer to DHCS. It is the intent of the parties that this contract remain in effect only until the earlier of the date that DHCS and the MHP execute a successor MHP contract or December 31, 2012.

5. Definitions.

The definitions contained in Title 9, Section 1810, shall apply in this contract.

A. "Beneficiary" means a Medi-Cal recipient who is currently receiving services from the Contractor.

B. "Contractor" means .

C. "Covered Mental Health Services" means mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, psychiatric health facility services, and targeted case management as defined in Title 9, CCR, Section 1810.247, to the extent described in Title 9, CCR, Section 1810.345, and in California's Medicaid State Plan Sections Supplement 3 to Attachment 3.1-A, Supplement 2 to Attachment 3.1-B and Supplement 1 to Attachment 3.1-A. Covered mental health services also includes, psychiatric inpatient hospital services as defined in Title 9, CCR, Section 1810.238, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services as defined in 1810.215. Psychiatric nursing facility services are not included.

D. "Department" means the California Department of Mental Health through June 30, 2012. On and after July 1, 2012, "Department" means the California Department of Health Care Services (DHCS).

E. "DHCS" means the California Department of Health Care Services.

F. "Director" means the Director of the California Department of Mental Health through June 30, 2012. On and after July 1, 2012, "Director" means the Director of DHCS.

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

H. "MCO" means Managed Care Organization.

I. "PAHP" means Prepaid Ambulatory Health Plan as defined in Title 42, Code of Federal Regulations (CFR), Section 438.2.

J. "PIHP" means Prepaid Inpatient Health Plan as described in Title 42 CFR Section 438.2. A PIHP is an entity that:

1) Provides medical services to beneficiaries under contract with the Department, and on the basis of prepaid capitation payments, or other payment arrangement that does not use state plan rates;

2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and

3) Does not have a comprehensive risk contract.

K. "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.

6. State and Federal Law Governing this Contract.

A. Contractor agrees to comply with all applicable federal and state law, particularly the statutes and regulations incorporated by reference below, in its provision of services as the Mental Health Plan. The Department will endeavor to notify Contractor of any changes to these statutes and regulations. Contractor agrees to comply with any changes to these statutes and regulations that may occur during the contract period, but either the Department or Contractor may request consultation and discussion of such changes, including whether contract amendments may be necessary.

B. Federal Law:

1) Title 42, United States Code;

2) Title 42, Code of Federal Regulations (CFR), to the extent that these requirements are applicable;

3) Title 42, CFR; Part 438 – Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHP);

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

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

6) Title IX of the Education Amendments of 1972;

7) Age Discrimination Act of 1975;

8) Rehabilitation Act of 1973;

9) Titles II and III of the Americans with Disabilities Act;

10) Deficit Reduction Act of 2005;

11) Balanced Budget Act of 1997.

C. State Law:

1) Division 5, W&I Code;

2) Part 2 (commencing with Section 5718, Chapter 3, W&I Code;

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

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

5) Title 9, CCR, Chapter 11 (commencing with Section 1810.100) – Medi-Cal Specialty Mental Health Services.

This Page is Intentionally Blank

EXHIBIT A1

Service Delivery, Administrative and Operational Requirements

1. Provision of Services.

A. The Contractor shall provide, or arrange and pay for, all medically necessary Covered Mental Health Services to beneficiaries, as defined for the purposes of this contract, of Monterey County.

B. The Contractor shall ensure that all medically necessary Covered Mental Health 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 Mental Health Service solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

C. The Contractor shall make all medically necessary Covered Mental Health Services available in accordance with Title 9, CCR, Sections 1810.345 and 1810.405 and Title 42 CFR, 438.210 and shall ensure:

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

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

3) Timely access to routine services determined by the Contractor to be required to meet beneficiaries' needs.

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

E. 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 Title 9 CCR, Section 1810.405 apply to out-of-plan services as well as in-plan services.

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

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

H. For services provided pursuant to Section 3 of this Exhibit, 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 coding.

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

2. Availability and Accessibility of Service.

A. The Contractor shall ensure the availability and accessibility of adequate numbers and types of providers of medically necessary services. At a minimum, the Contractor shall ensure an adequate number of providers and appropriate types of providers by considering:

1) The anticipated number of Medi-Cal eligible clients.

2) The expected utilization of services, taking into account the characteristics and mental health needs of beneficiaries pursuant to Title 42, CFR, 438.207(b).

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

4) The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

B. The Contractor shall ensure that treatment for urgent conditions is authorized within one hour of the request per Title 9, CCR, Section 1810.405(c).

C. Pursuant to Title 42 CFR, Section 438.206(c)(1)(ii), if a subcontract provider also serves individuals who are not Medi-Cal beneficiaries, the Contractor shall require that the hours of operation during which services are provided to Medi-Cal beneficiaries are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor, or another Mental Health Plan.

D. Pursuant to ,Title 42, CFR, 438.207, whenever there is a change in the Contractor's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries, the Contractor shall report this to the Department, including details regarding the change and plans to maintain adequate services and providers available to beneficiaries.

E. Access Standards (Title 42, CFR Section 438.206)

1) Out-of-Network Providers. Pursuant to Title 42, CFR, Section 438.206(b)(4), and to the extent required by CCR Title 9, Section 1830.220 for inpatient services, if the Contractor is unable to provide necessary medical services covered under the contract to a particular beneficiary, the entity must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them.

2) Out-of-Network Providers. Pursuant to Title 42, CFR, Section 438.206(b)(5) and consistent with CCR, Title 9, Section 1830.220, the Contractor shall ensure that out-of-network providers coordinate

authorization and payment with the Contractor. The Contractor must ensure that cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network, consistent with CCR, Title 9, Section 1810.365.

3) Timely Access. Pursuant to Title 42, CFR, Section 438.206(c)(1)(i), the Contractor must meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services.

4) Timely Access. Pursuant to Title 42, CFR, Section 438.206(c)(1)(iii), services must be available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.

5) Timely Access Monitoring. Pursuant to Title 42, CFR, Section 438.206(c)(1)(iv), (v) and (vi), the Contractor must:

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

   b) Monitor regularly to determine compliance;

   c) Take corrective action if there is a failure to comply.

F. Documentation of adequate capacity and services. Pursuant to Title 42, CFR, Section 438.207(b), the Contractor must, if requested by the Department, submit documentation to the Department, in a format specified by the Department, and after receiving reasonable advance notice of its obligation to demonstrate that the Contractor:

1) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries for the service area.

2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

G. Primary care and coordination of health care services. The Contractor must implement procedures to:

1) Coordinate the services the Contractor furnishes or arranges to be furnished to the beneficiary with the services the beneficiary receives from any other MCO, PIHP, or PAHP.

2) Share with other MCOs, PIHPs, and PAHPs serving the beneficiary the results of its identification and assessment of any beneficiary with special health care needs (defined as adults who have a serious mental disorder and children with a serious emotional disturbance as defined in Welfare and Institutions Code Section 5600.3) so that those activities need not be duplicated.

3) Ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with Title 45, CFR Parts 160 and 164 to the extent that such provisions are applicable.

4) 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.

(a) The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans.

3. Emergency Psychiatric Condition Reimbursement.

A. 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.

B. "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.

C. The Contractor shall comply with Title 42, CFR, Section 438.114, regarding emergency, post stabilization services. For purposes of this section, emergency and post stabilization services includes acute psychiatric inpatient hospital professional services (as defined in Title 9, CCR, Section 1810.237.1) which are related to an emergency medical condition or post-stabilization care. The Contractor shall apply the definitions contained in Title 42, CFR, Section 438.114. To the extent that there is a conflict between the definitions in Title 42, CFR, Section 438.114, and the Contractor's obligations as described in this section, the federal regulation shall prevail.

1) If an emergency room provider, hospital or fiscal agent of a provider or hospital does not notify the Contractor of the beneficiary's

screening and treatment, the Contractor must allow a minimum of ten calendar days after the beneficiary presents for emergency services or acute psychiatric inpatient hospital professional services before refusing to cover emergency services or acute psychiatric inpatient hospital professional services for this reason.

2) A beneficiary who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

3) The attending emergency physician, or the provider actually treating the beneficiary, is responsible for determining when the beneficiary is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in Title 42, CFR, 438.114(b), as responsible for coverage and payment.

D. The Contractor shall comply with Title 42, CFR, 438.114(d)(ii) and Title 9, CCR, Section 1820.225, regarding prior payment authorization for an emergency admission, whether voluntary or involuntary.

E. The Contractor shall comply with Title 9, CCR, Section 1830.215, regarding payment authorizations.

4. Provider Selection and Certification.

A. 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.

B. The Contractor shall comply with the provisions of Title 42, CFR, 455.104; Title 42, CFR, 455.105; Title 42, CFR, 1002.203; and Title 42, CFR, 1002.3, which relate to the provision of information about provider business transactions and provider ownership and control, prior to entering into a contract and during certification or re-certification of the provider.

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

D. Pursuant to Title 42, CFR, Section 438.12(a)(1), and Title 42, CFR, 438.214(c), the Contractor may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

E. The Contractor shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract;

F. As required by Title 42, CFR, 438.214(c), the Contractor shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

G. Structure and operational standards.

1) Pursuant to Title 42, CFR, Section 438.12(a) and 438.214, and Title 9, CCR, Section 1810.435, the Contractor must have written policies and procedures for selection, retention, and nondiscrimination of providers.

2) The Contractor must follow the Department's policies for credentialing and recredentialing providers of service. Further, pursuant to Title 42, CFR, Section 438.206(b)(6), the Contractor must demonstrate that its providers are credentialed.

H. 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 prior to the date on which the provider begins to deliver services under the contract, and once every three years after that date. The on-site review required by 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.

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

J. 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.

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

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

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

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

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

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

6) The organizational provider maintains client records in a manner that meets the requirements of the Contractor, the requirements of Section 15 of this Exhibit, and applicable state and federal standards.

7) The organizational provider has sufficient staff to allow the Contractor to claim federal financial (FFP) participation for the services the organizational provider delivers to beneficiaries, as described in Title 9, CCR, Section 1840, 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's head of service, as defined in Title 9, CCR, Sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.

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

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

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

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

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

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

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

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

L. 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 A1, Section 8.

M. When an on-site review of an organizational provider would not otherwise be required and the provider offers day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Exhibit A1, Section 8.

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

O. On-site review is not required for primary care and psychological clinics, as defined in section 1204.1 of the Health and Safety Code and licensed under Division 2, Chapter 1 of the Health and Safety Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license.

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

1) The provider makes major staffing changes.

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

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

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

5) There is a change of ownership or location.

6) There are complaints regarding the provider.

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

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

5. Recovery from Other Sources or Providers.

A. 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.

B. The monies recovered are retained by the Contractor; however, Contractor's claims for federal financial participation for services provided to beneficiaries under this contract shall be reduced by the amount recovered.

C. The Contractor shall maintain accurate records of monies recovered from other sources.

D. 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.

6. Subrogation.

In the event a beneficiary is injured by the act or omission of a third party, or has a potential or existing claim for a workers' compensation award, or a claim/recovery through uninsured motorist coverage, the right to pursue subrogation and the receipt of payments shall be as follows:

A. Contractor may submit to the Department claims for Medi-Cal covered services rendered, but Contractor shall not make claims to or attempt to recoup the value of these services from the above-referenced entities.

B. Contractor shall notify the California Department of Health Care Services within 10 days of discovery of all cases that could reasonably result in recovery by the beneficiary of funds from a third party, third party insurance carrier, workers' compensation award, and/or uninsured motorist coverage.

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

D. The Contractor also agrees to assist the Department of Health Care Services, upon request, to provide within thirty (30) days, payment information and copies of paid invoices/claims for covered services.

E. 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 to subcontracted providers or out-of-plan providers for similar services.

F. The information provided to the Department of Health Care Services shall include the following data:

1) Beneficiary name;

2) 14-digit Medi-Cal number;

3) Social security number or Client Identification Number (CIN);

4) Date of birth;

5) Contractor name;

6) Provider name (if different from Contractor);

7) Dates of service;

8) Diagnosis code and/or description of illness;

9) Procedure code and/or description of services rendered;

10) Amount billed by a Subcontractor or out-of-plan provider to the Contractor (if applicable);

11) Amount paid by other health insurance to the Contractor or Subcontractor;

12) Amount and date paid by the Contractor to subcontractor or out-of-plan provider (if applicable); and

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

G. The Contractor shall also provide the Department of Health Care Services with 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.

H. Information sent to the Department of Health Care Services, pursuant to this section, shall be sent to: California Department of Health Care Services, Third Party Liability Branch, 1500 Capitol Ave., Suite 320, Sacramento, CA 95814.

7. Beneficiary Brochure and Provider List.

A. The Contractor shall be responsible for the production and update of its booklet and provider list in accordance with Title 42, CFR, Section 438.10

and Title 9, CCR, Section 1810.360. The Contractor shall establish criteria to update its booklet and provider list.

Pursuant to Title 42, CFR, 438.10, the Contractor shall:

1) Notify all beneficiaries of their right to change providers;

2) Notify all beneficiaries of their right to request and obtain the following information:

   a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the beneficiary's service area, including identification of providers that are not accepting new patients.

   b) Any restrictions on the beneficiary's freedom of choice among network providers.

   c) Beneficiary rights and protections, as specified in Title 42, CFR 438.100.

   d) The amount, duration, and scope of benefits available under this Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.

   e) Procedures for obtaining benefits, including authorization requirements.

   f) The extent to which, and how, beneficiaries may obtain benefits.

   g) The extent to which, and how, after-hours and emergency coverage are provided, including:

      i. What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in Title 42, CFR, 438.114(a).

      ii. The fact that prior authorization is not required for emergency services.

      iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.

v. The fact that, subject to the provisions of Title 42, CFR, 438.10(f)(6), the beneficiary has a right to use any hospital or other setting for emergency care.

vi. The post-stabilization care services rules set forth in Title 42, CFR, 422.113(c).

h) Cost sharing, if any.

i) How and where to access any benefits that are available under the State Plan but are not covered under this Contract, including any cost sharing, and how any necessary transportation is provided. Pursuant to Title 42, CFR, Section 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. Pursuant to Title 42, CFR, Section 438.102(b)(1), the Contractor must provide information about the services it does not cover on moral or religious grounds.

B. The Contractor shall ensure that the general program literature it uses to assist beneficiaries in accessing services including, but not limited to, the booklet required by Title 9, CCR, Section 1810.360(d), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and mental health education materials used by the Contractor are available in the threshold languages of the County in compliance with Title 42, CFR, 438.10.

Pursuant to Title 42, CFR, 438.10(g) and Title 9, CCR 1850.205(c)(1), the booklet shall include grievance, appeal and fair hearing procedures and timeframes, as provided in Title 42, CFR, 438.400 through 438.424, using a Department-developed or Department-approved description that must include the following:

1) For State Fair Hearing (Title 42, CFR 431 Subpart E):

a) The right to hearing;

b) The method for obtaining a hearing; and

c) The rules that govern representation at the hearing.

2) The right to file grievances and appeals.

3) The requirements and timeframes for filing a grievance or appeal

4) The availability of assistance in the filing process.

5) The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone.

6) The fact that, when requested by the beneficiary —

   a) Benefits will continue if the beneficiary files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and,

   b) The beneficiary may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the beneficiary.

7) The appeal rights that the Department has chosen to make available to providers in Title 9, CCR 1850.315 to challenge the Contractor's failure to cover a service.

8) Advance Directives, as set forth in Title 42, CFR, 438.6(i)(1).

9) Additional information that is available upon request, including the following:

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

   b) Physician incentive plans as set forth in Title 42, CFR, Section 438.6(h), if they are used by Contractor.

C. The Contractor shall provide beneficiaries with a copy of the booklet and provider list when the beneficiary first accesses services and thereafter upon request in accordance with Title 9, CCR, Sections 1810.360 and 1810.110.

D. The Contractor shall not make changes to any of the content in the statewide section of the booklet unless directed to do so, in writing, by the Department;

E. The Contractor shall ensure any changes to the English version of the booklet are also included in the county's threshold languages and made available in alternate formats appropriate to the beneficiary population;

F. The Contractor shall ensure written materials are produced in a format that is easily understood;

G. The Contractor shall ensure that the booklet above includes the current toll-free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week.

H. The Contractor shall ensure that provider directories:

1) Include information on the category or categories of services available from each provider;

2) Contain the names, locations, and telephone numbers of current contracted providers by category;

3) Identify options for services in languages other than English and services that are designed to address cultural differences and;

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

When there is a change in the scope of specialty mental health services covered by the Contractor, the update, in the form of a booklet insert, shall be provided to beneficiaries at least 30 days prior to the change.

8. Requirements for Day Treatment Intensive and Day Rehabilitation.

A. The Contractor shall require providers to request MHP payment authorization for day treatment intensive and day rehabilitation services:

1) In advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.

2) At least every three months for continuation of day treatment intensive.

3) At least every six months for continuation of day rehabilitation.

4) Contractor shall also require providers to request MHP authorization for mental health services (as defined in Title 9, CCR, Section 1810.227) provided concurrently with day treatment intensive or day rehabilitation, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253. These services shall be authorized with the same frequency as the concurrent day treatment intensive or day rehabilitation services.

B. The Contractor shall not delegate the MHP payment authorization function to providers. When the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization function does not include staff involved in the provision of day treatment intensive, day rehabilitation services, or mental health services provided concurrent to day treatment intensive or day rehabilitation services.

C. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of Title 9, CCR, Sections 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352.

D. The Contractor shall require that providers include, at a minimum, the following day treatment intensive and day rehabilitation service components:

1) Community meetings. These meetings shall occur at least once a day to address issues pertaining to the continuity and effectiveness of the therapeutic program, and shall actively involve staff and clients. Relevant discussion items include, but are not limited to: the day's schedule, any current event, individual issues that clients or staff wish to discuss to elicit support of the group and conflict resolution. Community meetings shall:

a) For day treatment intensive, include a staff person whose scope of practice includes psychotherapy.

b) For day rehabilitation, include a staff person who is a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; and a registered nurse, psychiatric technician, licensed vocational nurse, or mental health rehabilitation specialist.

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

strategies for symptom reduction, increasing adaptive behaviors, and reducing distress.

3) Process groups. These groups, facilitated by staff, shall assist each client to develop necessary skills to deal with his/her problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.

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

5) Adjunctive therapies. These 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 should be able to utilize the modality to develop or enhance skills directed towards client plan goals.

E. Day treatment intensive shall additionally include:

1) Psychotherapy. Psychotherapy is the use of psychological techniques designed to encourage communication of conflicts and insight into problems with the goal of relieving symptoms, changing behavior leading to improved social and vocational functioning, and personality growth. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice.

2) Mental Health Crisis Protocol. This is 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 the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the client is linked to an outside crisis service.

3) Written Weekly Schedule. The program shall have a detailed schedule that identifies when and where the service components of

the program will be provided and by whom. The program staff, their qualifications, and the scope of their responsibilities are specified. The schedule is available to clients and, as appropriate, to their families, caregivers or significant support persons.

F. Staffing ratios shall be consistent with the requirements in Title 9, CCR, Section 1840.350, for day treatment intensive, and Section 1840.352 for day rehabilitation. For day treatment intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.

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

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

I. The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). There shall 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.

J. If a beneficiary is unavoidably absent for some part of the hours of operation, the Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day.

K. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation standards described in Section 13 of this Exhibit.

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

ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

M. Written Program Description. Day treatment intensive and day rehabilitation providers, including Contractor staff, shall develop and maintain a written program description that describes the specific activities of each service and reflects each of the required components of the services as described in this section. The Contractor shall review the description for compliance with this section prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

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

9. Therapeutic Behavioral Services.

A. Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as defined in Title 9, CCR, Section 1810.215.

B. TBS is an intensive, one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis and need additional short-term support services.

C. TBS shall not be provided unless it is necessary to prevent a beneficiary's 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, or for a beneficiary who has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

10. Procedures for Serving Child Beneficiaries Placed Out-of-County.

A. The Contractor in the child's county of origin shall provide or arrange for medically necessary specialty mental health services for children in a foster care aid code residing outside their county of origin.

B. The Contractor shall use the standard forms issued by the Department when a child in a foster care aid code is placed outside of his/her county of origin. The standard forms are:

1) Client Assessment,

2) Client Plan,

3) Service Authorization Request,

4) Client Assessment Update,

5) Progress Notes – Day Treatment Intensive Services,

6) Progress Notes – Day Rehabilitation Services,

7) Organizational Provider Agreement (Standard Contract).

C. For children in a foster care aid code, the Contractor in the child's county of origin shall make payment arrangements with the host county Mental Health Plan or with the requesting provider within 30 days of the date that the MHP in the child's county of origin authorized services. If the Contractor requires the use of a contract, the contract must be executed within 30 days of the date services were authorized.

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

E. The Contractor shall ensure that the MHP in the child's adoptive parents' county of residence provides medically necessary specialty mental health services to a child in an AAP aid code residing outside his or her county of origin in the same way as the MHP would provide services to an in-county child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS).

F. The MHP in the child's legal guardians' county of residence shall provide medically necessary specialty mental health services to a child in a Kin-GAP aid code residing outside his or her county of origin in the same way that it would provide services to any other child for whom the MHP is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS).

G. The Contractor shall comply with timelines specified in Title 9, CCR, Section 1830.220(b)(4)(A)(1-3), when processing or submitting authorization requests for children in a foster care, Adoption Assistance Program (AAP), or Kinship Guardian Assistance Payment (Kin-GAP) aid code living outside his or her county of origin.

H. The Contractor shall submit changes to its procedures for serving beneficiaries placed outside their counties of origin pursuant to Welfare and Institutions Code Section 5777.6(a) and(b) when those changes affect 25 percent or more of the Contractor's beneficiaries placed out of county. The Contractor's submission shall also include significant changes in the description of the Contractor's procedures for providing out-of-plan services in accordance with Title 9, CCR, Section 1830.220, when a beneficiary requires services or is placed in a county not covered by the Contractor's normal procedures.

11. Quality Management (QM) Program.

A. The Contractor's Quality Management (QM) Program shall improve Contractor's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

B. The Contractor shall have a written description of the QM Program which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

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

D. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.

E. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Title 42, CCR, Section 438.240(b)(3).

F. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:

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

2) Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
3) Evaluating requests to change persons providing services at least annually.

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

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

H. The Contractor shall implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.

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

J. The Contractor shall have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan shall include:

1) Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;

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

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

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

b) Objectives, scope, and planned QM activities for each year; and,

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

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

5) Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

12. Quality Improvement (QI) Program.

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

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

C. The QI Program shall be accountable to the Contractor's Director as described in Title 9 CCR, Section 1810.440(a)(1).

D. Operation of the QI program shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4).

E. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as consumers and family members in the planning, design and execution of the QI Program, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

F. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

G. QI activities shall include:

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

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

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

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

5) Designing and implementing interventions for improving performance;

6) Measuring effectiveness of the interventions;

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

8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5).

13. Quality Assurance (QA).

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

A. Assessment.

1) The following areas shall be included, as appropriate, as part of a comprehensive client record when an assessment has been performed. For children or certain other beneficiaries unable to provide a history, this information may be obtained from the parents/care-givers, etc.

a) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level

of functioning, relevant family history and current family information;

b) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;

c) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

d) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: Include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;

e) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;

f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

g) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals;

h) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;

i) A mental status examination;

j) A complete five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-code shall be

documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,

k) Additional clarifying formulation information, as needed.

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

B. Client Plans.

1) Client Plans shall:

a) Have specific observable and/or specific quantifiable goals/treatment objectives;

b) Identify the proposed type(s) of intervention/modality;

c) Have a proposed frequency and duration of intervention(s);

d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Title 9, CCR, Section 1830.205(b));

e) Have interventions that are consistent with the client plan goal;

f) Be consistent with the qualifying diagnoses;

g) Be signed (or electronic equivalent) by:

i The person providing the service(s), or,

ii A person representing a team or program providing services, or

iii A person representing the Contractor providing services;

iv By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved category:

A. A physician,

B. A licensed/waivered psychologist,

C. A licensed/registered/waivered social worker,

D. A licensed/registered/waivered marriage and family therapist,

E. A registered nurse;

h) Include documentation of the beneficiary's participation in and agreement with the client plan, as described in Title 9, CCR, Section 1810.440(c)(2)(A)(B).

i Examples of acceptable documentation include, but are not limited to, reference to the beneficiary's participation and agreement in the body of the plan, beneficiary signature on the plan, or a description of the beneficiary's participation and agreement in the client record;

ii The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:

A. The beneficiary is expected to be in long term treatment as determined by the MHP and,

B. The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service;

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

2) The Contractor shall offer a copy of the client plan to the beneficiary.

3) Timeliness/Frequency of Client Plan. The client plan shall be updated at least annually, or when there are significant changes in the client's condition.

C. Progress Notes.

1) Progress notes shall describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the client's progress in treatment include:

a) Timely documentation of relevant aspects of client care, including documentation of medical necessity;

b) Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

d) The date the services were provided;

e) Referrals to community resources and other agencies, when appropriate;

f) Documentation of follow-up care, or as appropriate, a discharge summary; and

g) The amount of time taken to provide services;

h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable

2) Timeliness/Frequency of Progress Notes. Progress notes shall be documented at the frequency by type of service indicated below:

a) Every Service Contact:

i Mental Health Services;

ii Medication Support Services;

iii Crisis Intervention;

iv Targeted Case Management;

b) Daily:

i Crisis Residential;

ii Crisis Stabilization (1x/23hr);

iii Day Treatment Intensive; and

c) Weekly:

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

ii Day Rehabilitation;

iii Adult Residential.

D. Other.

1) All entries to the client record shall be legible.

2) All entries in the client record shall include:

a) The date of service;

b) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title; and the relevant identification number, if applicable.

c) The date the documentation was entered in the client record.

14. Utilization Management (UM) Program.

A. The Utilization Management Program shall be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Title 9, CCR, Section 1810.440(b)(1-3).

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

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

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

The Contractor shall implement mechanisms to assure authorization decision standards are met. Authorization of services shall include all of the following:

1) Pursuant to Title 42, CFR, Section 438.210(b)(1), the Contractor and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.
2) Pursuant to Title 42, CFR, Section 438.210(b)(2), the Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.
3) Pursuant to Title 42, CFR, Section 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.
4) Decisions must be made within the timeframes outlined for service authorizations in Title 42, CFR Section 438.210(d), and notices of action related to such decisions must be provided within the timeframes set forth in Title 42, CFR, Section 438.404.(c).

E. Compensation for Utilization Management Activities.: Pursuant to Title 42, CFR, Section 438.210(e), compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

15. Additional Provisions.

A. Books and Records.

The Contractor shall maintain such books and records as are necessary to disclose how the Contractor discharged its obligations under this contract. These books and records shall identify 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 who received covered services, the manner in which the Contractor administered the provision of specialty mental health services and the cost thereof.

Such books and records shall include, but are not limited to, all physical records originated or prepared pursuant to 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 notified that the Department, DHCS, 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, including the exhaustion of all legal remedies, whichever is later.

The Contractor agrees to include in any subcontract for a sum in excess of $10,000 which utilizes state funds, a provision that states: "The contracting parties shall be subject to the examination and audit of the Department or 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 Department and the State Auditor General for a period of three years after final payment under contract (Government Code Section 8546.7).

B. 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 mental health care for beneficiaries in Monterey County. 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 that is 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.

C. Department Policy Letters.

The Contractor shall comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9, CCR, Section 1810.226. Policy letters shall provide specific details of procedures established by the Department for performance of contract terms when procedures not

covered in this agreement are determined to be necessary for performance under this agreement, but are not intended to change the basis and general terms of the contract.

D. Delegation.

Unless specifically prohibited by this contract or by federal or state law, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. In addition, Contractor may accept the certification of a provider by another Mental Health Plan, or by the Department, in order to meet the Contractor's obligations under Exhibit A1, Section 4. However, regardless of any such delegation to a subcontracting entity or acceptance of a certification by another MHP, Contractor shall remain ultimately responsible for adequate performance of all duties and obligations under this contract.

16. Beneficiary Problem Resolution Processes.

A. General Provisions.

The Contractor shall represent the Contractor's position in fair hearings (as defined in Title 9, CCR, Section 1810.216.6) dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this contract. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

1) Pursuant to Title 42, CFR, Section 438.228 and Title 9, CCR, Section 1850.205, the Contractor shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties under this Chapter, including the delivery of specialty mental health services.

2) The Contractor's beneficiary problem resolution processes shall include:

a) A grievance process;

b) An appeal process; and,

c) An expedited appeal process.

3) For the grievance, appeal, and expedited appeal processes, described in Title 42, CFR, Subpart F, and Title 9, CCR, Sections 1850.206, 1850.207 and 1850.208 respectively, the Contractor shall comply with all of the following requirements:

a) Assure that each beneficiary has adequate information about the Contractor's problem resolution processes by taking at least the following actions:

i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 7 of this contract.

ii. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to Title 9, CCR, Section 1850.210. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain specialty mental health services.

iii. Pursuant to Title 9 CCR Section 1850.205(c)(1)(C), making available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all Contractor provider sites without having to make a verbal or written request to anyone.

iv. Pursuant to 42, CFR, Section 438.406(a), giving beneficiaries any reasonable assistance in completing the forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

b. The Contractor shall acknowledge receipt of each grievance appeal, and request for expedited appeal to the beneficiary in writing.

c. A beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process, if the provider consents.

d. A beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

e. At the beneficiary's request, the Contractor shall identify staff or another individual to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing specialty mental health services to the beneficiary requesting assistance, the Contractor shall identify another individual to assist that beneficiary.

f. A beneficiary shall not be subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

g. Procedures for these beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information.

h. A procedure shall be included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. These issues shall be considered in the Contractor's Quality Improvement Program, as required by Title 9, CCR, Section 1810.440(a)(5).

i. Individuals involved in any previous review or decision-making on the issue(s) presented in a problem resolution process shall not participate in making the decision on the grievance, appeal, or expedited appeal.

j. The individual making the decision on the grievance, appeal, or expedited appeal shall have the appropriate clinical expertise, as determined by the Contractor, required to treat

the beneficiary's condition, if the grievance concerns the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal addresses any clinical issue, including a lack of medical necessity per 42 CFR 438.406(a)(3)(ii).

4) Pursuant to record keeping and review requirements in Title 42, CFR, 438.416, and to facilitate monitoring consistent with Title 9, CCR, Sections 1810.440(a)(5), 1850.205,1850.206, 1850.207, and 1850.208, the Contractor shall:

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

b. Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log;

c. Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal;

d. Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing;.

e. Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the beneficiary;

f. Notify the beneficiary, in writing, of the final disposition of the problem resolution process. The notification shall include the reasons for the disposition; and

g. Notify, in writing, any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

5) No provision of a 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.

B. Grievance Process.

Consistent with Title 42, CFR, Section 438.400 and Title 9, CCR, Section 1850.206, the grievance process shall, at a minimum:

1) Allow beneficiaries to present their grievance orally, or in writing;

2) 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. If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Title 9, CCR, Section 1810.230.5.

3) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

C. Appeal Process.

1) Consistent Title 42, CFR, Section 438.408 and Title 9, CCR, Section 1850.205 and 1850.207, the appeal process shall, at a minimum:

a) Allow a beneficiary to file an appeal orally or in writing;

b) Pursuant to Title 42, CFR, 438.402(b)(3), require a beneficiary who makes an oral appeal, that is not an expedited appeal, to subsequently submit the appeal in writing. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes;

c) Pursuant to Title 42, CFR, 438.408(a-c), 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. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Title 9, CCR, Section 1810.230.5;

d) Pursuant to Title 42, CFR, Section 438.408(e), inform the beneficiary of his or her right to request a fair hearing after the appeal process of the Contractor has been exhausted;

e) Allow the beneficiary to have a reasonable opportunity to present evidence and arguments of fact or law, in person and/or in writing, in accordance with the beneficiary's election ;

f) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process, provided that there is no disclosure of the protected health information of any individual other than the beneficiary;

g) 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.

2) Pursuant to Title 42, CFR, 438.408(d-e), the Contractor shall notify the beneficiary, and/or his or her representative, of the resolution of the appeal in writing. The notice shall contain:

a) The results of the appeal resolution process;

b) The date that the appeal decision was made;

c) 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 fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal.

d) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall include information on the beneficiary's right to continue to receive benefits while the fair hearing is pending and how to request the continuation of benefits. Such notice shall state that the beneficiary could be held liable for the cost of services received, if his or her appeal is not granted as a result of the fair hearing.

3) If the decision of the appeal resolution process reverses a decision to deny, limit or delay services, the Contractor shall promptly provide or arrange and pay for the services at issue in the appeal.

D. Expedited Appeal Process.

"Expedited Appeal" means an appeal, as defined in Title 9, CCR, Section 1810.203.5 and 1810.216.2, to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal as established in Title 9, CCR, Section 1850.207 would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. In addition to meeting the requirements of Title 42, CFR, Section 438.410(a), and Title 9, CCR, Section 1850.205, 1850.207(a),(d),(e),(f),(g), and(i), and 1850.208, the expedited appeal process shall, at a minimum:

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

2) Pursuant to Title 42, CFR, Section 438.402(b)(3), the Contractor must allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.

3) Ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

4) Pursuant to Title 42, CFR, Section 438.408(a-c), the Contractor must resolve an expedited 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 beneficiary, notify the beneficiary of the extension

and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Title 9, CCR, Section 1810.230.5.

5) Pursuant to Title 42, CFR, Section 438.408(d)(2), the Contractor must provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. The written notice shall meet the requirements of Section 1850.207(h).

6) Pursuant to Title 42, CFR, Section 438.410(c), if the Contractor denies a request for expedited appeal resolution, the Contractor shall:

   a) Transfer the expedited appeal request to the timeframe for appeal resolution as required by Title 9, CCR, Section 1850.207(c).

   b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in Title 9, CCR, Section 1810.230.5.

E. Beneficiary Problem Resolution Processes Established by Providers.

Nothing in Title 9, CCR, Sections 1850.205, 1850.206, 1850.207, 1850.208 and 1850.209 precludes a provider other than the Contractor from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the Contractor to use or exhaust the provider's processes prior to using the Contractor's beneficiary problem resolution process, unless the following conditions have been met:

1) The Contractor 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 of the contract, the relevant provisions of Title 42, CFR, Subpart F, Title 9, CCR, Sections 1850.205 and 1850.209, and depending on processes delegated, Title 9, CCR, Sections 1850.206, 1850.207, and/or 1850.208; and

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

F. Fair Hearing.

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, CCR, Sections 50951 and 50953 and Title 9, CCR, Section 1810.216.6. Fair hearings must comply with Title 42, CFR, Sections 431.200(b), 431.22(a)(5), 438.408(b & f), 438.414, and 438.10(g)(1).

1) If a beneficiary requests a State Fair Hearing, the Department (not the Contractor) shall grant the request. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or notice of action. Beneficiaries and providers shall also be informed of the following:

   a) A beneficiary may request a State Fair Hearing.

   b) The provider may request a State Fair Hearing only if the Department permits the provider to act as the beneficiary's authorized representative.

   c) The Department must permit the beneficiary to request a State Fair Hearing within a reasonable time period specified by the Department, not in excess of 90 days from whichever of the following dates applies:

      i From the date indicated on the Contractor's notice of action, if the Department does not require exhaustion of the Contractor-level appeal procedures and the beneficiary appeals directly to the Department for a fair hearing.

      ii From the date indicated on the Contractor's notice of resolution, if the Department requires exhaustion of Contractor-level appeals.

2) The Department must reach its decisions within the specified timeframes:

   a) Standard resolution: within 90 days of the date the beneficiary filed the appeal with the Contractor, if the beneficiary filed initially with the Contractor (excluding the days the beneficiary took to subsequently file for a State Fair

Hearing), or the date the beneficiary filed for direct access to a State Fair Hearing.

b) Expedited resolution (if the appeal was heard first through the Contractor appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that:

i Meets the criteria for an expedited appeal process but was not resolved using the Contractor's expedited appeal timeframes, or

ii Was resolved wholly or partially adversely to the beneficiary using the Contractor's expedited appeal timeframes.

3) Pursuant to Title 42, CFR, Section 438.408(f)(2), the parties to the State Fair Hearing include the Contractor as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

G. Expedited Fair Hearing.

"Expedited Fair Hearing" means a fair hearing, as defined in Title 42, CFR, 438, Subpart F, Title 9, CCR, Sections 1810.216.4 and 1810.216.6, to be used when a Mental Health Plan determines, or the beneficiary and/or the beneficiary's provider certifies, that that following the timeframe for a fair hearing as established in Title 42, CFR, Section 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

H. Continuation of Services Pending Fair Hearing Decision.

1) 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 the outcome of a fair hearing pursuant to Title 22, Section 51014.2, and Title 9, CCR, Section 1850.215.

2) The Contractor shall continue to provide specialty mental health services pending the outcome of a fair hearing in accordance with Title 22, Section 51014.2. If the Contractor allows providers to deliver specialty mental health services for a set number of visits or a set duration of time without prior authorization, the Contractor shall continue to provide specialty mental health services pending the outcome of a fair hearing when the Contractor denies a payment authorization request from a provider requesting continuation of services beyond the number or duration permitted