COUNTY OF SAN MATEO
Departmental Correspondence

DATE. MAY 2 2 2001
HEARING DATE: JUN 0 5 2001

TO Honorable Board of Supervisors

FROM Beverly Abbott, Director, Mental Health Services

SUBJECT Managed Care Agreement with the State Department of Mental Health

RECOMMENDATION

Adopt a resolution authorizing the President of the Board to execute an agreement with the State Department of Mental Health (DMH)

Background

The Mental Health Services Division has operated a managed care system for Medi-Cal eligibles since April 1, 1995 Operating under a waiver granted by the Health Care Financing Administration (HCFA), the Division has provided a range of services to approximately 5,000 Medi-Cal clients a year At the end of the initial two-year waiver period, the Division worked with DMH and the State Department of Health Services to submit a second waiver request. The second waiver was designed to test additional program elements, including a new system for earning Medi-Cal reimbursement and additional responsibility for pharmacy and lab services HCFA approved the two-year waiver effective July 1, 1998 The HCFA waiver was extended through 2000-01. This DMH Managed Care Agreement authorizes the San Mateo Mental Health Plan to provide mental health services to Medi-Cal eligible clients and provides State General Fund revenue to support managed care and other specified services.

Discussion

The agreement continues all prior year contract requirements for managing services to Medi-Cal eligible clients, including quality assurance, record keeping, client rights, funding, and availability and accessibility of services. In addition, it continues the unique requirements of the San Mateo County field test waiver including case rate reimbursements, responsibility for medications prescribed by psychiatrists, and laboratory services.

The agreement includes the state share of funding for 2000-01, a total of $9,448,900 This represents funding for the current managed care program, children's system of care and specialized Medi-Cal services The state share of cost for Medi-Cal expenses for pharmacy and laboratory services is increased 17 5% over the 1999-2000 funding level. This represents the estimated cost increases for these services as negotiated in the original federal HCFA waiver

Outcome Measure	1999-2000 Actual	2000-2001 Objective
Medi-Cal Penetration Rate *	12 9%	Maintain at above 12%

Outcome Measure	1999-2001 Budgeted Growth	1999-2000 Actual Growth	2000-2001 Growth Objective
Pharmacy Cost Growth	25% per year	16%	Maintain at 15% or less

Outcome Measure	1999-2000 Actual	2000-2001 Objective
Total # of Medi-Cal Clients	5395 (54%)	56%
Cost per Client w/o Pharmacy	$5,830	Maintain at $6,146 or less
Total Cost per Client	$6,854	Maintain at $7,195 or less

* Number of Mental Health Medi-Cal clients served as percentage of total County Medi-Cal beneficiaries

Term

The agreement is effective from July 1, 2000 through June 30, 2001 and has been reviewed and approved by County Counsel. The agreement is being submitted late due to errors in the Medi-Cal case rates initially provided by the State Department of Mental Health. These errors have been corrected in the contract being submitted to your Board.

Fiscal Impact

The amount of the agreement is $9,448,900 for 2000-2001. This includes $6,926,037 as the state share of Medi-Cal expenses for pharmacy and laboratory services, $1,797,955 for current managed care clinical services and $724,908 for children's services. In addition to the state allocation, the agreement authorizes an estimated $12,860,000 in federal Medi-Cal (FFP) collections through case rates and $5,000,000 in FFP for pharmacy and laboratory services. The total anticipated federal revenue is $17,860,000 There is no net county cost for providing these services to Medi-Cal eligibles The revenue and expenses are included in the 2000-2001 Mental Health Services budget.

RECOMMENDED

Margaret Taylor

HEALTH SERVICES DEPARTMENT

RESOLUTION NO. _____

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

* * * * * * * * * *

RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT WITH THE STATE DEPARTMENT OF MENTAL HEALTH (DMH)

RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that;

WHEREAS, there has been presented to this Board of Supervisors for its consideration and acceptance an agreement, reference to which is hereby made for further particulars, whereby the state has designated San Mateo County to field test a managed mental health plan; and

WHEREAS, there has been presented to this Board of Supervisors for its consideration and acceptance an Agreement, reference to which is hereby made for further particulars, whereby the county shall provide managed Medi-Cal services; and

WHEREAS, this Board has been presented with a form of the Agreement and has examined and approved it as to both form and content and desires to enter into the Agreement:

NOW, THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that the Request for Proposals process is waived, and the Board hereby authorizes the President of this Board of Supervisors to execute said Agreement for and on behalf of the County of San Mateo, and the Clerk of this Board shall attest the President s signature thereto.

STAT. OF CALIFORNIA

STANDARD AGREEMENT — APPROVED BY THE ATTORNEY GENERAL

STD 2 (REV 6 91)

CONTRACT NUMBER	AM NO
00-70059-000	

TAXPAYER S FEDERAL EMPLOYER IDENTIFICATION NUMBE
94-60005532

THIS AGREEMENT made and entered into this 1st day of July 2000
in the State of California by and between State of California through its duly elected or appointed qualified and acting

TITLE OF OFFICER ACTING FOR: DEPUTY DIRECTOR | AGENCY: Department of Mental Health hereafter called the State and

CONTRACTOR S NAME: San Mateo County Mental Health Services hereafter called the Contractor

WITNESSETH That the Contractor for and in consideration of the covenants conditions agreements and stipulations of the State hereinafter expressed does hereby agree to furnish to the State services and materials as follows *(Set forth service to be rendered by Contractor amount to be paid Contractor time for performance or completion and attach plans and specifications if any)*

ARTICLE I - PREAMBLE

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

WHEREAS Part 2 5 (commencing with Section 5775) of Division 5 of the W&I Code directs the State Department of Mental Health to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state and San Mateo County Mental Health desires to operate the Mental Health Plan for San Mateo County

NOW THEREFORE the parties agree to enter into a contract for this purpose in accordance with the following provisions

CONTINUED ON_____ SHEETS EACH BEARING NAME OF CONTRACTOR AND CONTRACT NUMBER

The provisions on the reverse s de hereof constitute a part of this agreement
IN WITNESS WHEREOF this agreement has been executed by the parties hereto upon the date first above written

STATE OF CALIFORNIA	CONTRACTOR
AGENCY: Department Of Mental Health	CONTRACTOR: San Mateo County Mental Health Services
BY (AUTHORIZED SIGNATURE)	BY (AUTHORIZED SIGNATURE)
PRINTED NAME OF PERSON SIGNING: LINDA A POWELL DEPUTY DIRECTOR	PRINTED NAME AND TITLE OF PERSON SIGNING: MICHAEL D. NEVIN, PRESIDENT, BOARD OF SUPERVIS(
TITLE: Administrative Services	ADDRESS: 225 West 37th Avenue, San Mateo CA 94403

AMOUNT ENCUMBERED BY THIS DOCUMENT: $ $9 448 900 00	PROGRAM/CATEGORY (CODE AND TITLE): 10 25 Community Service - O T		FUND TITLE: General Fund		*Department of General Services Use Only*
PRIOR AMOUNT ENCUMBERED FOR THIS CONTRACT: $ $0 00	(OPTIONAL USE): PCA 27266 PCA 23334				
TOTAL AMOUNT ENCUMBERED TO DATE: $ $9 448 900 00	ITEM: 4440-103-0001 $2,522,863 4440-101-0001 $6,926,037	CHAPTER: 52	STATUTE: 2000	FISCAL YEAR: 2000-2001	
	OBJECT OF EXPENDITURE (CODE AND TITLE)				

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purpose of the expenditure stated above | T B A NO | B R NO

SIGNATURE OF ACCOUNTING OFFICER | DATE

☐ CONTRACTOR ☐ STATE AGENCY ☐ DEPT OF GEN SER ☐ CONTROLLER ☐

1. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract.

2. The Contractor, and the agents and employees of Contractor, in the performance of the agreement, shall act in an independent capacity and not as officers or employees or agents of State of California.

3. The State may terminate this agreement and be relieved of the payment of any consideration to Contractor should Contractor fail to perform the covenants herein contained at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. The cost to the State shall be deducted from any sum due the Contractor under this agreement, and the balance, if any, shall be paid the Contractor upon demand.

4. Without the written consent of the State, this agreement is not assignable by Contractor either in whole or in part.

5. Time is of the essence in this agreement.

6. No alteration or variation of the terms of this contract shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein, shall be binding on any of the parties hereto.

7. The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel and per diem, unless otherwise expressly so provided.

ARTICLE II - DEFINITIONS

Unless otherwise expressly provided or the context otherwise requires the following definitions of terms will govern the construction of this contract·

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

B Contractor means San Mateo County Mental Heath Services.

C Covered Services means·

1. Specialty mental health services as defined in Title 9, CCR Section 1810 247, to the extent described in Title 9 CCR Section 1810.345, except that psychiatric nursing facility services are not included and

2 Prescription drugs prescribed by a psychiatrist to treat the mental health condition of a beneficiary and laboratory services required as a direct corollary of the covered prescription drugs, e.g., blood tests to monitor drug levels or drug side effects.

D. Department means the State Department of Mental Health.

E "Director' means the Director of the State Department of Mental Health.

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

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

1 A danger to self or others, or

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

H. Facility means any premises:

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

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

I. Individual provider' means a provider as defined in Title 9, CCR, Section 1810.222.

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

K Medi-Cal managed care plan means an entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries under Chapter 7, commencing

with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3 of the W&I Code

L Organizational provider" means a provider as defined in Title 9, CCR, Section 1810 231.

M 'Psychiatric nursing facility services means services as defined in Title 9, CCR, Section 1810.239.

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

O "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.

P 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

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

ARTICLE III -- GENERAL PROVISIONS

A. Governing Authorities

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

Part 2 5 (commencing with Section 5775), Chapter 4 Division 5, W&I Code;

Article 5 (Sections 14680- 14685) Chapter 8 8 Division 9, W&I Code;

Chapter 11 (commencing with Section 1810.100), Title 9, CCR, except as specifically provided in this contract. Program flexibility pursuant to Title 9, CCR, Section 1810 110(c) shall apply to the San Mateo County contract for the purpose of testing elements of the specialty mental health service delivery system including but not limited to, the provision of pharmacy and laboratory services and claiming of federal financial participation;

Title 42, Code of Federal Regulations (CFR)

Title 42, United States Code;

All other applicable laws and regulations.

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

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

B. Fulfillment of Obligation

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

C Amendment of Contract

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

D Contract Disputes

Should a dispute arise between the Contractor and the Department relating to performance under this contract other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, Title 9, CCR the Contractor will, prior to exercising any other remedy which may be available provide the Department with written notice of the particulars of the dispute within 30 calendar days of the dispute The Department will meet with the Contractor, review the factors in the dispute, and recommend a means of resolving the dispute before a written response is given to the Contractor. The Department will provide a written response to the Contractor within 30 days of receipt of the Contractor's written notice.

E Inspection Rights

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

F Notices

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

California Department of Mental Health
Technical Assistance and Training
Systems of Care Division
1600 Ninth Street Room 100
Sacramento, CA 95814

San Mateo County Mental Health Services
225 West 37th Avenue
San Mateo, CA 94403
Attn: Beverly K. Abbott, Director

G Budget Contingencies

1 Federal Budget

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

b. This contract is subject to any additional restrictions, limitations or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms, or funding of this contract in any manner.

c. The State and the Contractor agree that if Congress enacts such changes during the term of this contract, both parties will meet and confer to renegotiate the terms of this contract affected by the restrictions, limitation, conditions or statute enacted by Congress.

2 State Budget

a. This contract is subject to any restrictions, limitations or conditions enacted by the Legislature and contained in the Budget Act or any statute enacted by the Legislature that may affect the provisions, terms or funding of this contract in any manner. The State and the Contractor agree that if statutory or regulatory changes occur during the term of the contract which affect this contract, both parties may renegotiate the terms of this contract affected by the statutory or regulatory changes.

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

H. Confidentiality

1. The parties to this agreement will comply with applicable laws and regulations, including but not limited to Section 5328 et seq. and Section 14100.2 of the W&I Code and Title 42 CFR, Section 431 300 et seq. regarding the confidentiality of beneficiary information.

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

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

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

l Nondiscrimination

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

2. During the performance of this contract, the Contractor and its subcontractors will not unlawfully discriminate against any employee or applicant for employment because of race religion color national origin ancestry, mental or physical handicap, medical conditions, marital status, age or sex The Contractor and its subcontractors will comply with the Disabilities Act of 1990, the Fair Employment and Housing Act (Government Code, Section 12900 et seq), and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285 et seq) The Contractor will ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5, Division 4 of Title 2 CCR, are incorporated into this contract by reference and made a part hereof as if set forth in full. The Contractor and its subcontractors will give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

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

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

5. Notwithstanding other provisions of this section the Contractor may require a determination of medical necessity pursuant to Title 9, CCR, Section 1820.205, Section 1830 205 or Section 1830 210, prior to providing covered services to a beneficiary.

J Patients' Rights

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

K. Relationship of the Parties

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

L. Severability

If any provision of this contract or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction or is found by a court to be in contravention of any federal or state law or regulation, the remaining provisions of this contract or the application thereof will not be invalidated thereby and will remain in full force and effect and to that extent the provisions of this contract are declared severable

M Waiver of Default

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

N. Drug-Free Workplace Certification

By signing this contract, the Contractor hereby certifies that the Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350 et seq.) and will provide a drug-free workplace doing all of the following:

1 Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations, as required by Government Code Section 8355(a).

2 Establish a Drug-Free Awareness Program, as required by Government Code Section 8355(a) to inform employees about all of the following.

a. the dangers of drug abuse in the workplace,

2 Establish a Drug-Free Awareness Program as required by Government Code Section 8355(a) to inform employees about all of the following

a the dangers of drug abuse in the workplace

b the Contractor s policy of maintaining a drug-free workplace

c any available counseling rehabilitation and employee assistance programs and

d penalties that may be imposed upon employees for drug abuse violations

3. Provide as required by Government Code Section 8355(a) that every employee who works on the contract:

a will receive a copy of the Contractor s drug-free policy statement and

b will agree to abide by the terms of the Contractor s statement as a condition of employment on the contract or grant

Failure to comply with these requirements may result in suspension of payments under the contract or termination of the contract or both and the Contractor may be ineligible for award of future state contracts if the Department determines that any of the following has occurred. (1) the Contractor has made a false certification or (2) violates the certification by failing to carry out the requirements as noted above

O. Year 2000 Compliance

The Contractor warrants and represents that the goods or services sold leased or licensed to the State of California, its agencies or its political subdivisions pursuant to this contract are Year 2000 compliant For purposes of this contract a good or service is Year 2000 compliant if it will continue to fully function before at and after the Year 2000 without interruption and if applicable with full ability to accurately and unambiguously process display compare, calculate, manipulate, and otherwise utilize date information. This warranty and representation supersedes all warranty disclaimers and limitations and all limitations on liability provided by or through the Contractor.

P. Child Support Compliance

1 The contractor recognizes the importance of child and family support obligations and shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including but not limited to disclosure of information and compliance with earnings assignment orders as provided in Chapter 8 commencing with Section 5200 of Part 5 of Division 9 of the Family Code.

2. The contractor to the best of its knowledge, is fully complying with the earnings assignment orders of all employees and is providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department

ARTICLE IV -- TERM AND TERMINATION

A Term of Contract

This contract will become effective on July 1, 2000 and will continue in full force and effect through June 30 2001, subject to the provisions of Article III, Section G because the State has currently appropriated and available for encumbrance only funds to cover costs through June 30 2000.

B Contract Renewal

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

C Contract Termination

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

D Mandatory Termination

The Department shall immediately terminate this contract in the event that the Director determines that there is an immediate threat to the health and safety of beneficiaries The department shall terminate this contract in the event that the Secretary, HHS, determines that the contract does not meet the requirements for participation in the Medicaid program Title XIX of the Social Security Act. Terminations under this section will be in accordance with Title 9, CCR, Section 1810 325

E Termination of Obligations

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

ARTICLE V - DUTIES OF THE CONTRACTOR

In discharging its obligations under this contract the Contractor shall perform the following:

A Provision of Services

Provide or arrange and pay for covered services to beneficiaries, as defined for the purposes of this contract, of San Mateo County.

In determining whether a service is covered under this contract based on the diagnosis of the beneficiary, the Contractor may not exclude a beneficiary solely on the grounds that the provider making the diagnosis has used the International Classification of Diseases (ICD) diagnosis system rather than the system contained in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. For services provided pursuant to Section C the Contractor will 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.

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

295.00 – 298 9	302.8 - 302.9	311 - 313.82
299.1 – 300 89	307 1	313.89 – 314.9
301 0 – 301.6	307 3	332.1 – 333.99 *
301 8 – 301.9	307.5 - 307.89	787.6
302.1 – 302 6	308 0 - 309.9	

*Note· Treatment of diagnoses 332 1 - 333.99, Medication Induced Movement Disorders, is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.

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

290 12 – 290 21	299.10 - 300.15	308.0 – 309.9
290.42 – 290.43	300 2 - 300.89	311 – 312.23
291 3	301 0 - 301.5	312.33 - 312.35
291 5 - 291.89	301.59 - 301 9	312.4 – 313.23
292.1 - 292.12	307.1	313 8 – 313.82
292 84 – 292.89	307.20 - 307.3	313 89 - 314.9
295.00 – 299.00	307.5 - 307.89	787.6

B. Availability and Accessibility of Service

Ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites and professional allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis.

C Prescription Drugs and Related Laboratory Services

Provide or arrange and pay for prescription drugs and related laboratory services as covered services as defined for the purpose of this contract to beneficiaries Ensure the timely and efficient processing of authorization requests for covered prescription drugs by providing a response within 24 hours or one business day to a request for prior authorization made by telephone or other telecommunication devise and providing for the dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation. Pursuant to the exemption under Title 9 CCR Section 1810.110(c), for prescription drugs only, the definition of emergency psychiatric condition shall, at a minimum, include situations in which a delay in dispensing the drug is likely to result in the beneficiary needing crisis services.

D. Emergency Psychiatric Condition Reimbursement

Pay for covered services other than prescription drugs for emergency psychiatric conditions received by a beneficiary from providers whether or not the provider has a subcontract with the Contractor Covered services including prescription drugs provided for emergency psychiatric conditions will not be subject to prior authorization by the Contractor.

E Organizational and Administrative Capability

Have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract. This will include as a minimum the following:

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

2. Beneficiary problem resolution processes.

3. Provider problem resolution and appeal processes

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

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

F Quality Management

Implement a Quality Management Program in accordance with Title 9, CCR, Section 1810 440 and Attachment A (consisting of three pages) and Attachment B (consisting of two pages), which are incorporated herein by reference, for evaluating the appropriateness and quality of the covered services provided to beneficiaries References to the mental health plan (MHP) in Attachments A and B are references to the Contractor. Provide the Department with reports generated through the Quality Management Program on request.

Ensure that all covered services delivered by organizational providers are provided under the direction of a physician· a licensed/waivered psychologist· a licensed/registered/waivered

social worker, a licensed/registered/waivered marriage, family and child counselor; or a registered nurse.

G Beneficiary Records

Maintain at a site designated by the Contractor for each beneficiary who has received services a legible record kept in detail consistent with Attachment C (consisting of three pages), which is incorporated herein by reference and good professional practice which permits effective quality management processes and external operational audit processes, and which facilitates an adequate system for follow-up treatment References to the client in Attachment C are references to beneficiaries who have received services through the Contractor If a beneficiary receives only psychiatric inpatient hospital services, the Contractor need not maintain a record for the beneficiary in addition to the record maintained by the facility provided the Contractor and appropriate oversight entities have access to the facility's record as provided in Article VIII Section 4.f

H. Review Assistance

Provide any necessary assistance to the Department in its conduct of facility inspections and operational reviews of the quality of care being provided to beneficiaries, including providing the Department with any requested documentation or reports in advance of a scheduled on site review. Contractor will correct deficiencies as identified by such inspections and reviews according to the time frames delineated in the resulting reports.

I Implementation Plan

Pursuant to the exemption under Title 9, CCR Section 1810 110(c), the Contractor is not required to submit or maintain an Implementation Plan pursuant to Title 9 CCR, Section 1810.310. The Department accepts the Contractor s protocols and procedures as described in the Medi-Cal Managed Care Field Test (San Mateo County) waiver request that was approved by federal Health Care Financing Administration on June 18, 1998 as consistent with Implementation Plan requirements The Contractor shall submit any significant changes to these procedures and protocols to the Department for approval consistent with the procedures and timelines of Title 9, CCR, Section 1810.310(e).

J. Memorandum of Understanding with Medi-Cal Managed Care Plans

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. 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. Pursuant to the exemption under Section 1810.110(c), effective January 1, 1999 when covered services include prescription drugs and related laboratory services, Section 1810.370(a)(4)(A) shall not apply.

K Cultural Competence Plan

Provide the Department with a Cultural Competence Plan that meets the requirements of Title 9, CCR, Section 1810.410, and the requirements of the Department s Information Notice Number 97-14, entitled 'Plan for Culturally Competent Specialty Mental Health

Services," dated October 6 1997, in accordance with dates to be established by the Department.

L. Certification of Organizational Providers

Certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR Section 1810.435 and the requirements specified in Attachment D (consisting of two pages), which is herein incorporated by reference, prior to the date on which the provider begins to deliver services under the contract and once every two years after that date, except as provided in this section and in Attachment D. The on site review required by Title 9, CCR Section 1810 435(d) as a part of the certification process, will 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.

If the Department has performed a similar certification of the provider for participation in the Short-Doyle/Medi-Cal program certification by the Contractor is not required prior to delivery of services under this contract and the next certification will be due within two years of the date of the last certification by the Department, except as provided in Attachment D.

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

The Contractor may allow an organizational provider to continue delivering covered services to beneficiaries at a site subject to on site review as part of the biennial 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 biennial recertification of the provider is due.

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

M Recovery from Other Sources or Providers

Recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance. The moneys recovered are retained by the Contractor; however, contractor claims for federal financial participation for services provided to beneficiaries under this contract will be reduced by the amount recovered.

N Third-Party Tort and Casualty Liability Insurance

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

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

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

   a. Beneficiary name.

   b Full 14 digit Medi-Cal number

   c. Social Security Number.

   d Date of birth.

   e. Contractor name

   f. Provider name (if different from the Contractor)

   g. Dates of service.

   h. Diagnosis code and/or description of illness.

   I. Procedure code and/or description of services rendered.

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

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

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

   m Date of denial and reasons (if applicable).

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

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

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

O Financial Resources

Maintain adequate financial resources to carry out its obligation under this contract.

P Financial Report

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

Q Books and Records

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

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

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

R. Transfer of Care

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

S Department Policy Letters

Comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9 CCR Section 1810.226 Policy letters will 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.

T. Delegation

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

U. Fair Hearings

Represent the Contractor's position in fair hearings (as defined in title 9, CCR, Section 1810.216.1) dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. 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.

V. Encounter Data Reporting

Report all services except prescription drugs and related laboratory services provided to beneficiaries to the Department in accordance with the requirements of the Client and Services Information System (CSIS). Comply with Title 9, CCR, Section 1840.304 when submitting data for services billed by individual or group providers using service codes from the Health Care Financing Administration s Common Procedure Coding System (HCPCS). At such time as the table currently included in Section 1840.304 is deleted from the section, the Contractor shall follow the table issued by the Department as a DMH Information Notice.

Report prescription drug and related laboratory services to the Department in accordance with the requirements of the Department of Health Services' Managed Care Encounter Data Reporting System. Pharmacy and laboratory services data reported shall include the data elements specified in Attachment E. Data shall be submitted to the Department on a monthly basis not later than 90 days following the end of the month in which the service was provided.

1 The Contractor shall ensure that, upon written notice by the Department of any problems related to the submittal of data or any other changes or clarification related to encounter data reporting that the Contractor will submit a corrective action plan with measurable benchmarks within ten working days from the postmark date of the Department's notice or a later date if allowed by the Department.

2. The Contractor shall ensure that data submitted to the Department is complete and accurate in accordance with CSIS or Managed Care Encounter Data Reporting system requirements Upon written notice by the Department that data is insufficient or inaccurate, the Contractor shall ensure that corrected data is submitted within fifteen working days of the postmark date of the Department's notice, or a later date if allowed by the Department.

W Claims Invoicing to the Department

Submit a monthly invoice to the Department to obtain reimbursement of federal financial participation for covered services under this contract. At a minimum, the invoice will contain the following information·

1. The total amount for case rates and the total expenditures for pharmacy and laboratory services as separate line items

2 Federal financial participation at the appropriate percentage, and

3. Certification by the Mental Health Director or designee that:

   a) to the best of his or her knowledge and belief, this claim is in all respects accurate, correct complete, and in accordance with law.

   b) required matching funds are available prior to the reimbursement of federal funds.

The invoice shall be accompanied by the following information:

1. Aggregate case rate detail: The case rate and number of clients receiving services at each level of care and the total Medi-Cal amount for each level of care.

2. Client-level case rate billing detail: Displays each Medi-Cal client, including Medi-Cal Beneficiary Identification Number and the case rate claimed.

3. Pharmacy and laboratory services billing detail: Detail will be separately displayed for pharmacy and laboratory services for each beneficiary obtaining services to include the information required by the Department of Health Services' Managed Care Encounter Data Reporting System. At the Contractor's election, the pharmacy and laboratory

services billing detail may be submitted in accordance with Section V above, rather than as an attachment to the monthly invoice

Pursuant to the exemption under Title 9 CCR, Section 1810.110(c), the Contractor shall claim federal financial participation in accordance with this section and the provisions of Article VII rather than in accordance with Title 9, CCR, Division 1, Chapter 11, Subchapter 4.

X Psychiatric Inpatient Hospital Services Claims Processing

Reimburse hospitals directly that were Fee-for-Service/Medi-Cal hospitals as defined in Title 9 CCR, Section 1810.217 serving San Mateo County beneficiaries prior to April 1, 1995 or that are currently operating as Fee-for-Service/Medi-Cal hospitals for beneficiaries of other counties. Pursuant to the exemption under Title 9, CCR Section 1810.110(c) the provisions of Title 9, CCR, Section 1820 220 and 1820 225 related to the submission of treatment authorization requests to the fiscal intermediary shall not apply.

Y Payment of Medicare Co-Insurance and Deductibles

Reimburse Medicare providers that provide Medicare services to beneficiaries for applicable co-insurance and deductibles For contract providers, reimbursement amounts shall be in accordance with the contract between the provider and the Contractor. For non-contract providers, reimbursement amounts shall be determined in accordance with procedures established by the Department of Health Services for the fee-for-service Medi-Cal program or at an amount agreed to by the provider and the Contractor consistent with federal and state laws and regulations Pursuant to the exemption under Title 9, CCR, Section 1810.110(c) reimbursement shall be made to Medicare providers whether the providers are hospital individual, group or organizational providers. Payment of a beneficiary's Medicare co-insurance and deductibles shall qualify for the payment of a case rate in accordance with the tables in Article VII at the lowest adult or child level, as applicable.

Z Beneficiary Brochure and Provider Lists

Provide beneficiaries with a brochure upon request and when a beneficiary first receives a specialty mental health service from the Contractor or its subcontracting providers, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Title 9, CCR, Section 1830 205 are met. The brochure shall contain a description of the services available; a description of the process for obtaining services, including the Contractor's statewide toll-free telephone number; the availability of a list of the Contractor s providers upon request; a description of the Contractor's beneficiary problem resolution process, including the complaint resolution and grievance processes· and a description of the beneficiary's right to request a fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process The description of the right to request a fair hearing shall include the information that a fair hearing may be requested whether or not the beneficiary uses the beneficiary problem resolution process and whether or not the beneficiary has received a notice of action pursuant to Title 9, CCR, Section 1850.210.

Provide beneficiaries with a list of the Contractor s providers upon request. The list shall include the providers names and addresses and shall include information on the category of

services available from each provider At a minimum the services available from the provider must be categorized as psychiatric inpatient hospital services, targeted case management services and/or all other specialty mental health services. The list may include instructions to the beneficiary explaining how appointments may be scheduled.

If beneficiary brochures issued by the Contractor prior to the effective date of this contract do not include all required information regarding the beneficiary's right to request a fair hearing or information about the availability of a list of the Contractor's providers upon request, the Contractor shall include this information in the next printing of the beneficiary brochure or no later than June 1, 2001, whichever is earlier.

ARTICLE VI -- DUTIES OF THE STATE

In discharging its obligations under this contract, the State will perform the following duties.

A. Payment for Services

Pay the appropriate payments set forth in Article VII.

B Reviews

Conduct reviews of access and quality of care at least once every 12 months and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate.

C Monitoring for Compliance

Monitor the operation of the Contractor for compliance with the provisions of this contract, and applicable federal and state law and regulations. Such monitoring activities will include, but not be limited to inspection and auditing of Contractor facilities, management systems and procedures and books and records as the Department deems appropriate at any time during the Contractor's or facility's normal business hours.

D Approval Process

1. In the event that the Contractor requests changes to its protocols and procedures pursuant to Article V, Section I, the Department will provide a Notice of Approval or Notice of Disapproval including the reasons for the disapproval, to the Contractor within 30 calendar days after the receipt of the request from the Contractor. The Contractor may implement the proposed changes 30 calendar days from submission to the Department, if the Department fails to provide a Notice of Approval or Disapproval.

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

3. The Department will act promptly to review requests from the Contractor for approval of subcontracts with pharmacy or laboratory service providers that meet the conditions described in Title 9, CCR Section 1810.438. The Department will act to approve or disapprove the reimbursement and related claiming and cost reporting issues included in the subcontract within 60 days of receipt of a request from the Contractor. If the Department disapproves the request, the Department will provide the Contractor with the reasons for disapproval. Pursuant to the exemption under Title 9, CCR, Section 1810 110(c), the provisions of Title 9, CCR, Section 1810.438 are not applicable to other types of providers

E Certification of Organizational Provider Sites Owned or Operated by the Contractor

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

If the Department has performed a similar certification of the Contractor's organizational provider sites for participation in the Short-Doyle/Medi-Cal program certification by the Department is not required prior to the date on which the Contractor begins to deliver services under this contract at these sites.

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

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

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

F. Continuation of the Medi-Cal Mental Health Care Field Test (San Mateo County)

Support continuation of the Medi-Cal Mental Health Care Field Test (San Mateo County) waiver under the Section 1915(b) of the Social Security Act subject to approval by the State Department of Health Services and the Health Care Financing Administration to the extent that the intent of Welfare and Institutions Code, Section 5719 5 continues to be met.

G Sanctions

Apply oversight and sanctions in accordance with Title 9, CCR Sections 1810 380 and 1810.385, to the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations.

H. Notification

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

ARTICLE VII -- PAYMENT

A Amounts Payable

The total amount payable for the 2000-2001 Fiscal Year ending June 30, 2001 is $9,448,900 00 Of the total amount payable for the 2000-2001 Fiscal Year $6 926 037.00 is for mental health pharmacy and related laboratory services and $121.00 is for additional state funds for covered services provided to beneficiaries residing in institutions for mental diseases. The amount payable is an interim amount only and is subject to the development of the allocation amount for the 2000-2001 Fiscal Year pursuant to Section D. Any requirement of performance by the Department and the Contractor for this period and for subsequent periods will be dependent upon the availability of future appropriations by the Legislature for the purpose of this contract

B Payment to the Contractor

The Contractor will receive a single payment for the full amount payable under Section A for the respective Fiscal Year within 60 calendar days of the determination of the amount by the Department in accordance with Title 9 CCR, Section 1810 330, or the enactment of the State Budget for the respective Fiscal Year whichever is later.

C Payment in Full

The amount payable under Section A, referred to hereafter as the allocation amount, constitutes payment in full by the Department of the State matching funds on behalf of beneficiaries for all covered services and for all utilization review and administrative costs incurred by the Contractor in providing or arranging for such services, except for the amount payable for pharmacy and laboratory services as described in Section D and Section J below, and for covered services to beneficiaries residing in institutions for mental diseases and for covered services, other than psychiatric inpatient hospital services provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits as described in this section

The total amount payable for fiscal year 2000-2001 in Section A includes an amount equal to state matching share of the historical cost of psychiatrist and psychologist services provided in the fee-for-service Medi-Cal program which is not separately identified. The total amount payable also includes a separately identified amount in Section A that equals the federal matching funds for these costs. This amount is included to reflect the fact that federal financial participation (FFP) is not available for these services. The separately identified amount for covered services to beneficiaries residing in institutions for mental diseases will be reviewed by the Department to ensure that the amount reasonably reflects the historical cost of psychiatrist and psychologist services provided in the fee-for-service Medi-Cal program. The amount payable under Section A for these services may be amended based on this review and the availability of state funds.

State matching funds, in addition to the amount payable under Section A, for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits will be paid in accordance with the Interagency Agreement between the Department and the State Department of Health Services (DHS 99-86346; DMH 99-79145-000 or subsequent

agreement), which provides the FFP and specified state matching funds for the Medi-Cal specialty mental health services and related activities

D. Determination of Allocation Amount

The allocation amount for all covered services except for pharmacy and related laboratory services will be set annually on a formula basis as determined by the Department in consultation with a statewide organization representing counties pursuant to Section 5778, W&I Code

The allocation amount for covered pharmacy services and related laboratory services for fiscal year 2000-2001 will be an amount based on the projections included in Medi-Cal Mental Health Care Field Test (San Mateo County) waiver renewal request that was submitted by DHS and approved by the Health Care Financing Administration on June 17, 1998, under Section 1915(b)(4) of the federal Social Security Act, adjusted for information obtained during operation of the benefit program from January 1, 1999 through June 30, 2000 and from other relevant sources. In the event that there is a delay in the execution of the respective contract amendment beyond date that funding for the allocation amount is approved through the State's budget process the Department may make the payment to the Contractor as an interim payment, which will be considered payment under this contract once the amendment is executed.

E. Renegotiation or Adjustment of Allocation Amount

1 To the extent permitted by federal law, either the Department or the Contractor may request that contract negotiations of the allocation amount be reopened during the course of a contract due to substantial changes in the cost of covered services or related obligations that result from new legislative requirements affecting the scope of services or eligible population or other unanticipated event. Any change in the allocation amount under this section is subject to the availability of funds. Any change in allocation amount will be retroactive to the effective date of the change authorizing the amendment

2 The allocation amount may be changed pursuant to a change in the obligation of the Contractor as a result of a change in the obligations of a Medi-Cal managed care plan for services that would be covered by the Contractor if they were not covered by the Medi-Cal managed care plan, pursuant to Title 9, CCR, Section 1810.345 and Section 1810 350(a)(5). Any change in allocation amount will be retroactive to the effective date of the change authorizing the amendment.

F. Disallowances and Offsets

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

G. Federal Financial Participation

FFP for covered services other than pharmacy and related laboratory services under this contract will be reimbursed using all-inclusive case rates. A case rate shall be paid on behalf of a beneficiary when a beneficiary accesses any covered service or a Medicare service for which a coinsurance or deductible payment is due in accordance with Section Y during the

month. The payment of a case rate shall constitute payment in full for the federal matching funds on behalf of the beneficiary for all covered services other than pharmacy and related laboratory services and for all utilization review and administrative costs incurred by the Contractor in providing or arranging for such services in that month. Pharmacy and laboratory services are not be included in the case rates. Case rates will be paid for the following distinct levels of care.

Adult Integrated Intensive Community Treatment - Services provided to adults who will be referred to the REACH program a comprehensive program for seriously mentally ill individuals

Adult Comprehensive Regional Services - All adults receiving full "system of care" services excluding the high utilizers included under Adult Integrated Intensive Community Treatment Clients receiving regional services will be authorized for all ranges of clinical services.

Adult Provider Network Services - Adults receiving episodic or lower levels of care. Services will be provided by contracted independent practitioners and community-based agencies.

Child Integrated Intensive Community Treatment - Services provided to youths authorized for intensive day treatment and/or residential care (level 13 and 14 in California's group home classification system), or an equivalent level of service.

Child Comprehensive Regional Services - All children authorized to receive services through the child and youth system of care Children receiving regional services will be authorized for all ranges of clinical services

Child Provider Network Services - Children receiving episodic or lower levels of care. As with adults, services will be provided by contracted independent practitioners and community-based agencies.

The FFP for the case rates will be paid monthly based on the actual number of Medi-Cal beneficiaries enrolled in each level of care during the preceding month, based on the monthly invoice submitted by the Contractor as required in Article V, Section W. Thus, the FFP will be paid retroactively based on actual Medi-Cal beneficiaries enrolled in a given level of service.

Nothing in this contract shall limit the Contractor from being reimbursed appropriate FFP for any covered services, or utilization review and administrative costs for pharmacy and laboratory services even if the total expenditure for services exceeds the contract amount. Matching nonfederal funds will be provided by the Contractor for the FFP matching requirement.

H. Out of County Services

FFP based on case rates will be paid for all beneficiaries, including those receiving covered services out-of-county. When beneficiaries receive covered services from a provider of another mental health plan and the other mental health plan claims FFP through the Short-Doyle/Medi-Cal claiming process the Department will offset the amount of the FFP claimed by the other mental health plan from a subsequent invoice from the Contractor. The

by the other mental health plan from a subsequent invoice from the Contractor The Department will periodically audit Short-Doyle/Medi-Cal paid claims for beneficiaries receiving services from oroviders of other mental health plans

When Medi-Cal beneficiaries whose county of responsibility as listed on MEDS is other than San Mateo County receive services from the Contractor or its providers or subcontractors the Contractor shall not include these beneficiaries in its invoice for case rates. In the absence of any other agreement with the mental health plan of that beneficiary, FFP shall be obtained by the Contractor through a Short-Doyle/Medi-Cal claim. The Contractor may negotiate an agreement with the mental health plan of that beneficiary to obtain any applicable state matching funds

I. Case Rates

Table 1 below displays the fiscal year 2000-2001 case rates. The rates displayed include both federal and state matching funds The Contractor shall invoice the Department for the appropriate FFP by multiplying the rate by the current federal Medicaid sharing percentage for California

Table 2
Fiscal Year 2000-2001 Case Rates
(FFP and State Match)

Service Level	FY 2000/01 Monthly Case Rates
Adult – Intensive Services	$2,956.37
Adult – Regional Services	$904.47
Adult – Provider Network	$188.82
Child – Intensive Services	$2,652.89
Child – Regional Services	$1,068.95
Child – Provider Network	$205.57

J Risk Corridor for State Medicaid Match for Covered Pharmacy and Laboratory Services

Pursuant to the Interagency Agreement between the Department and the Department of Health Services concerning this contract the Department of Health Services will share financial risk with the Contractor for the state matching funds for pharmacy and related laboratory services effective July 1 2000 The Contractor will be at full risk for the state allocation if the cost of pharmacy and related laboratory services exceeds the state allocation by ten percent or less The Department of Health Services will assume fifty percent of the risk if costs exceed the state allocation by more than ten percent up to fifty percent. The Department of Health Services will assume 100 percent of the risk if costs exceed the state allocation by more than fifty percent· however, if the costs exceed the allocation by more than fifty percent, tne Department and the Department of Health Services will reevaluate cost effectiveness of continuing pharmacy and related laboratory services under this contract. If the departments determine that coverage will be discontinued and submit a contract amendment to effect the change in accordance with Article III, Section D, the Contractor shall accept the amendment If the cost of services is less than the state allocation by more than

The Department will monitor the pharmacy and related laboratory services claims on a quarterly basis. The annual State General Fund allocation will be divided into quarterly amounts for comparison with actual claims. If actual claims differ from the quarterly allocation amount by more than ten percent, both on a quarterly and year-to-date basis, the Department will work with the Contractor to determine why the actual claims were higher or lower than allocations and determine whether this reflects an on-going trend. If the analysis indicates that actual reimbursement is going to exceed the State General Fund allocation by more than fifty percent, the Department, subject to availability of funds from the Department of Health Services, will provide additional State General Fund match to the Contractor The amount of interim additional State General Fund match will be negotiated between the Department and the Contractor, and will reflect revised estimates of actual costs and the risk corridor. If the analysis indicates that actual reimbursement is going to be less than fifty percent of the State General Fund allocation, the Department will notify the Contractor via written letter of the potential refund due to the State. The Department will require the Contractor to certify that it is aware of the refund liability and is taking appropriate actions to ensure such funds will be available for refund to the Department of Health Services at year-end settlement, if necessary.

The risk corridor will be applied to any differences between the final settlement amount and the State General Fund allocation.

ARTICLE VIII -- SUBCONTRACTS

A. Subcontracts

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

2. All subcontracts must be in writing except those for seldom-used or unusual goods and services.

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

4. Each subcontract must contain:

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

   b Specification of the services to be provided

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

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

   e. The nondiscrimination and compliance provisions of this contract as described in Article III, Section I.

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

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

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

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

Attachment A

Quality Improvement Program

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

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

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

- An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities:
- Monitoring of previously identified issues, including tracking of issues over time; and
- Objectives, scope, and planned activities for the coming year, including QI activities in each of the following areas.
    1. Monitoring the service delivery capacity of the MHP:
    - The MHP will implement mechanisms to assure the capacity of service delivery within the MHP
        - The MHP will describe the current number, types and geographic distribution of mental health services within its delivery system.
        - The MHP will set goals for the number, type, and geographic distribution of mental health services

2 Monitoring the accessibility of services:

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

3. Monitoring beneficiary satisfaction

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

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

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

5 Monitoring continuity and coordination of care with physical health care providers and other human services agencies

- The MHP will work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries
  - When appropriate the MHP will exchange information in an effective and timely manner with other agencies used by its beneficiaries
  - The MHP will monitor the effectiveness of its MOU with Physical Health Care Plans

6. Monitoring provider appeals

The following process will be followed for each of the QI work plan activities #1 - 6 identified above, to ensure the MHP monitoring the implementation of the QI Program. The MHP will follow the steps below for each of the QI activities:

1 collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified
2 identify opportunities for improvement and decide which opportunities to pursue
3. design and implement interventions to improve its performance
4. measure the effectiveness of the interventions

C If the MHP delegates any QI activities there will be evidence of oversight of the delegated activity by the MHP

- A written mutually agreed upon document will describe:
  - the responsibilities of the MHP and the delegated entity
  - the delegated activities
  - the frequency of reporting to the MHP
  - the process by which the MHP will evaluate the delegated entity s performance, and
  - the remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations

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

Attachment B

Utilization Management Program

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

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

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

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

ii) Approves the delegated entity's UM program annually

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

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

Contract Number 00-70059
Contractor Name San Mateo County Mental Health Services

Attachment C

Documentation Standards For Client Records

The documentation standards are described below under key topics related to client care There is no requirement that the record have a specific document or section addressing these topics.

A Assessments

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

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

2. Timeliness/Frequency Standard for Assessment

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

B. Client Plans

1. Client Plans will·

- have specific, observable or quantifiable goals
- identify the proposed type(s) of intervention

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

- In addition,

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

2. Timeliness/Frequency of Client Plan

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

C. Progress Notes

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

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

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

2 Timeliness/Frequency of Progress Notes:

Progress notes will be documented at the frequency by type of service indicated below.

a Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)

c. Weekly

- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential

d Other

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

Attachment D

Provider Certification by the Contractor or the Department

As a part of the organizational provider certification requirements in Article V, Section L and Article VI Section E, the Contractor and the Department respectively will verify, through an on-site review if required by those sections or if determined necessary by the Contractor or the Department respectively, that:

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

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

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

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

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

6 The organizational provider maintains client records in a manner that meets the requirements of the Contractor pursuant to Article V Section G, and applicable state and federal standards

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

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

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

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

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

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

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

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

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

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

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

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

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

When 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 two years. Additional certification reviews of organizational providers may be conducted by the Contractor or Department, as applicable at its discretion, if:

a) The provider makes major staffing changes

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

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

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

e) There is a change of ownership or location.

f) There are complaints regarding the provider.

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

Attachment E

Data Element	Field Name	Requirement
1	Claim Reference Number	
2	Plan Code	00503
3.	Format Code	P = Pharmacy; L = Lab
4	Program Code	P
7	Medi-Cal Beneficiary Identification	OK to zero fill
8	Social Security or Client Index Number	
9	Name of Medi-Cal Recipient	
10.	Birth Date of Medi-Cal Recipient	
11.	Sex Code of Medi-Cal Recipient	
13.	Provider Number	
14	Provider Name	PBM Provider Name OK
15.	ZIP Code of Provider	PBM ZIP Code OK
16	County Code of Provider	41
17	Provider Type Code	24 = Pharmacy; code lab services appropriately
19.	Beginning Date of Service	
20	Ending Date of Service	
21.	Referring/Prescribing/Admitting Provider	
23.	Primary Diagnosis	For Lab Services Only
27	Adjudication Status Code	P
28	Adjudication Date	Date of Service
29	Date of Payment by Plan	Same as Adjudication Date
30.	Billed Amount	
31	Reimbursement Amount	Report for Risk Corridor
32.	Patient Liability Amount	
33.	Medicare Deductible Amount	For Lab Services Only
34.	Medicare Co-Insurance Amount	For Lab Services Only
35.	Other Health Coverage Amount	
38.	Place of Service	99 = Pharmacy; 81 = Independent Lab
39.	Procedure Code	For Lab Services Only
40.	Procedure Modifier Code	For Lab Services Only
41.	Medical Outpatient Procedure Quantity	For Lab Services Only
42	Rendering Provider Number	For Lab Services Only
43	Drugs/Medical Supplies	National Drug Code
44	Drug/Medical Supply Indicator Code	1
45	Drug/Medical Supply Quantity	
46.	Days Supply	

Medi-Cal Antipsychotic Drug Expenditures for CY 1999

Generic Name	Number RXS	% of Class total	Amt Paid	% of Class Total
CHLORPROMAZINE HCL	48549	3%	2007539	1%
CLOZAPINE	234469	15%	26999948	11%
DROPERIDOL	43	0%	1666	0%
FLUPHENAZINE DEC/ENANTHATE	15920	1%	1257004	1%
FLUPHENAZINE HCL	60364	4%	2082950	1%
HALOPERIDOL	181110	11%	1282283	1%
HALOPERIDOL LACTATE	10581	1%	518663	0%
HALOPERIDOL DEC	20754	1%	4201562	2%
LOXAPINE SUCCINATE	5223	0%	660117	0%
MESORIDAZINE BESULATE	9221	1%	976974	0%
MOLINDONE HCL	3367	0%	460434	0%
OLANZAPINE	360213	22%	120051168	48%
PERPHENAZINE	36197	2%	1031131	0%
PIMOZIDE	769	0%	54867	0%
QUETIAPINE	71791	4%	15127475	6%
RISPERIDONE	320917	20%	64014862	26%
THIORIDAZINE	142701	9%	4976920	2%
THIOTHIXENE	46871	3%	1042747	0%
TRIFLUOPERAZINE	35937	2%	1739107	1%
CLASS TOTAL	**1604997**		**248,167,437**	

ATYPICAL ANTIPSYCHOTICS	Number RXS	% of Class total	Amt Paid	% of Class Total
CLOZAPINE	234469	24%	26999948	12%
OLANZAPINE	360213	36%	120051168	53%
QUETIAPINE	71791	7%	15127475	7%
RISPERIDONE	320917	33%	64014862	28%
Atypical total	**987390**		**226193453**	
	62% of all agents		**91% of all Agents**	
Conventional Antipsychotics				
Conventional Total	**617607**		**21,993,984**	
	38% of all agents		**9% of all agents**	

Medi-Cal Antipsychotic Drug
Expenditures for CY 2000

GENERIC NAME	NUMBER OF RXS	% Class Total	AMOUNT PAID	% Class Total
CHLORPROMAZINE HCL	44,924	2.5%	$ 2,081,628	0.6%
CLOZAPINE	237,239	13.3%	$ 30,246,595	9.3%
DROPERIDOL	102	0.0%	$ 8,802	0.0%
FLUPHENAZINE DECANOATE	16,669	0.9%	$ 1,299,208	0.4%
FLUPHENAZINE ENANTHATE	367	0.0%	$ 53,892	0.0%
FLUPHENAZINE HCL	54,974	3.1%	$ 2,013,241	0.6%
HALOPERIDOL	153,113	8.6%	$ 1,275,236	0.4%
HALOPERIDOL DECANOATE	20,319	1.1%	$ 3,988,286	1.2%
HALOPERIDOL LACTATE	12,932	0.7%	$ 813,416	0 2%
LOXAPINE HCL	131	0.0%	$ 37,939	0.0%
LOXAPINE SUCCINATE	6,691	0 4%	$ 974,280	0.3%
MESORIDAZINE BESYLATE	7,403	0 4%	$ 624,769	0 2%
MOLINDONE HCL	2,883	0.2%	$ 477,686	0.1%
OLANZAPINE	451,523	25.4%	$ 156,359,603	48.0%
PERPHENAZINE	31,010	1.7%	$ 927,678	0.3%
PIMOZIDE	854	0.0%	$ 60,500	0.0%
QUETIAPINE FUMARATE	127,843	7.2%	$ 29,651,348	9.1%
RISPERIDONE	421,670	23.7%	$ 87,442,311	26.8%
THIORIDAZINE HCL	116,318	6.5%	$ 4,982,879	1.5%
THIOTHIXENE	41,149	2.3%	$ 1,030,744	0.3%
THIOTHIXENE HCL	809	0.0%	$ 30,415	0.0%
TRIFLUOPERAZINE HCL	31,995	1.8%	$ 1,564,956	0.5%
Class Total	1,780,918		$ 325,945,412	
Cost per Rx	$ 183.02			

Atypical Antipsychotics

GENERIC NAME	NUMBER OF RXS	% Atypicals	AMOUNT PAID	% Atypicals
CLOZAPINE	237,239	19%	$ 30,246,595	10%
OLANZAPINE	451,523	36%	$ 156,359,603	51%
QUETIAPINE FUMARATE	127,843	10%	$ 29,651,348	10%
RISPERIDONE	421,670	34%	$ 87,442,311	29%
Total	1,238,275		$ 303,699,857	
% of Class Total	70%		93%	
Cost per Rx	$ 245.26			

Conventional Antipsychotics	NUMBER OF RXS	% Class Total	AMOUNT PAID	% Class total
Total	542,643	30%	$ 22,245,555	7%
Cost per Rx	$ 40.99			

ATTACHMENT 6

TOP 75 DRUGS IN 2000 (drugs bolded are not target drugs)

	Generic Name	Amount Paid	Number of Rxs
1	OLANZAPINE	$ 156,359,603	451,523
2	RISPERIDONE	$ 87,442,311	421,670
3	OMEPRAZOLE	$ 71,694,147	425,247
4	CELECOXIB	$ 61,574,940	549,499
5	**SOMATROPIN**	**$ 59,067,110**	**11,873**
6	LANSOPRAZOLE	$ 52,095,856	340,713
7	ATORVASTATIN CALCIUM	$ 44,259,506	396,890
8	FLUOXETINE HCL	$ 43,930,366	329,763
9	PAROXETINE HCL	$ 43,732,454	458,594
10	METFORMIN HCL	$ 35,974,618	474,133
11	DIVALPROEX SODIUM	$ 35,537,130	335,696
12	AMLODIPINE BESYLATE	$ 33,557,402	468,500
13	CLOZAPINE	$ 30,246,595	237,239
14	QUETIAPINE FUMARATE	$ 29,651,348	127,843
15	GABAPENTIN	$ 29,128,085	213,129
16	FAMOTIDINE	$ 28,030,365	322,340
17	PRAVASTATIN SODIUM	$ 27,231,261	228,488
18	NIFEDIPINE	$ 26,305,378	315,240
19	**ROFECOXIB**	**$ 24,679,701**	**276,065**
20	SIMVASTATIN	$ 24,585,959	175,799
21	**EPOETIN ALFA**	**$ 24,206,334**	**30,348**
22	ENALAPRIL MALEATE	$ 24,056,073	366,144
23	BUSPIRONE HCL	$ 22,764,539	186,744
24	**LORATADINE**	**$ 21,154,001**	**241,559**
25	**ZIDOVUDINE/LAMIVUDINE**	**$ 19,305,165**	**34,654**
26	**NELFINAVIR MESYLATE**	**$ 17,769,366**	**29,157**
27	DILTIAZEM HCL	$ 17,119,172	244,000
28	**ROSIGLITAZONE MALEATE**	**$ 16,589,569**	**107,635**
29	**LEVOFLOXACIN**	**$ 16,562,424**	**193,509**
30	BENAZEPRIL HCL	$ 16,528,797	340,169
31	**OXYCODONE HCL**	**$ 15,544,863**	**47,144**
32	GLYBURIDE	$ 15,469,793	304,653
33	TRAMADOL HCL	$ 14,860,083	225,646
34	ZOLPIDEM TARTRATE	$ 14,311,073	215,462
35	CLONAZEPAM	$ 13,714,237	298,491
36	NORGESTIMATE-ETHINYL ESTRADIOL	$ 13,638,585	173,213
37	**IPRATROPIUM BROMIDE**	**$ 13,625,872**	**184,831**
38	**STAVUDINE**	**$ 13,433,406**	**54,379**

ATTACHMENT 6

TOP 75 DRUGS IN 2000 (drugs bolded are not target drugs)

	Generic Name	Amount Paid	Number of Rxs
39	**LAMIVUDINE**	**$ 13,277,351**	**51,408**
40	**ALENDRONATE SODIUM**	**$ 12,497,691**	**150,596**
41	CIPROFLOXACIN HCL	$ 12,459,979	169,259
42	**INSUL NPH HU REC/INS RG HU REC**	**$ 12,435,631**	**174,079**
43	**RIBAVIRIN/INTERFERON A-2B**	**$ 11,653,557**	**11,196**
44	**MORPHINE SULFATE**	**$ 10,886,935**	**47,702**
45	**PIOGLITAZONE HCL**	**$ 10,855,404**	**58,665**
46	ESTROGENS,CONJUGATED	$ 10,744,608	250,247
47	ALBUTEROL SULFATE	$ 10,629,350	348,841
48	**BECLOMETHASONE DIPROPIONATE**	**$ 10,389,255**	**177,273**
49	**TRIAMCINOLONE ACETONIDE**	**$ 10,143,918**	**375,199**
50	LEVONORGESTREL-ETH ESTRA	$ 9,880,989	142,894
51	**FLUCONAZOLE**	**$ 9,743,571**	**85,639**
52	IBUPROFEN	$ 9,672,962	657,255
53	**BUPROPION HCL**	**$ 9,534,860**	**114,548**
54	**TERAZOSIN HCL**	**$ 9,144,777**	**106,634**
55	**LOSARTAN POTASSIUM**	**$ 9,042,312**	**137,281**
56	**VENLAFAXINE HCL**	**$ 8,957,999**	**86,187**
57	**INSULIN NPH HUMAN RECOM**	**$ 8,785,096**	**147,466**
58	**ABACAVIR SULFATE**	**$ 8,702,383**	**25,022**
59	**EFAVIRENZ**	**$ 8,649,496**	**23,222**
60	*ACETAMINOPHEN*	*$ 8,526,584*	*918,604*
61	**MEGESTROL ACETATE**	**$ 8,127,656**	**59,825**
62	**WARFARIN SODIUM**	**$ 7,899,859**	**238,044**
63	CODEINE PHOSPHATE/APAP	$ 7,830,580	1,054,992
64	**CLOPIDOGREL BISULFATE**	**$ 7,809,151**	**67,408**
65	**AMYLASE/LIPASE/PROTEASE**	**$ 7,569,395**	**73,276**
66	ISOSORBIDE MONONITRATE	$ 7,563,629	129,731
67	**CYCLOSPORINE, MODIFIED**	**$ 7,368,899**	**18,327**
68	**ETANERCEPT**	**$ 7,290,223**	**7,076**
69	**NEVIRAPINE**	**$ 7,208,581**	**25,919**
70	**MIRTAZAPINE**	**$ 7,205,979**	**77,678**
71	LEVOTHYROXINE SODIUM	$ 7,183,792	372,466
72	PHENYTOIN SODIUM EXTENDED	$ 7,156,753	209,083
73	**LATANOPROST**	**$ 7,046,158**	**128,390**
74	LISINOPRIL	$ 7,001,662	138,785
75	**FENTANYL**	**$ 6,981,357**	**25,766**