State of California

STANDARD AGREEMENT

STD. 213 (NEW 02/98)

Agreement Number: 03-73052-000

Amendment Nbr.:

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

State Agency's Name:

Department of Mental Health

Contractor's Name:

San Mateo County Mental Health Services

2. The Term of this Agreement is: **July 01, 2003 Through June 30, 2004**

3. The maximum amount of this agreement is: **$8,357,680.00**
Eight Million Three Hundred Fifty Seven Thousand Six Hundred Eighty Dollars And No Cents

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

Exhibit A - Scope of Work	Page(s)	34	
Exhibit B - Budget Detail and Payment Provision	Page(s)	6	
* Exhibit C - General Terms and Conditions	Form:	GTC 103	Dated 01/01/2003
Exhibit D - Special Terms and Conditions	Page(s)	4	
Exhibit E - Additional Provision	Page(s)	12	

*View at: http://www.ols.dgs.ca.gov/Standard+Language/default.htm

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

CONTRACTOR

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

San Mateo County Mental Health Services

BY *(Authorized Signature)*: Mark Church, President Board of Supervisors

DATE SIGNED:

PRINTED NAME AND TITLE OF PERSON SIGNING

Gail Bataille, Director Gail Bataille

ADDRESS **225 West 37th Avenue**
San Mateo, CA 94403

STATE OF CALIFORNIA

AGENCY NAME

Department of Mental Health

BY *Authorized Signature*:

DATE SIGNED:

PRINTED NAME AND TITLE OF PERSON SIGNING

William A. Avritt, Acting Deputy Director
Administrative Services

ADDRESS **1600 9th Street**
Sacramento, CA 95814

California
Department of General Services
Use Only

EXHIBIT A
SCOPE OF WORK
JULY 1, 2003 – JUNE 30, 2004

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

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

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

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

Department of Mental Health Ruth Walz (707) 252-3168 Fax: (707) 254-2421	San Mateo County Mental Health Gail Bataille, Director (650) 573-2544 Fax: (650) 573-2841

Direct all inquiries to:

Department of Mental Health Technical Assistance and Training 1600 9th Street, Room 100 Sacramento, CA 95814	San Mateo County Mental Health 225 West 37th Avenue Sacramento, CA 94403

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

5. See Exhibit A, Attachment 1, which is made part of this contract, for a detailed description of the work to be performed.

SERVICE DELIVERY. ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS

A. Provision of Services

The Contractor shall 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 D, 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

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

C. Prescription Drugs and Related Laboratory Services

The Contractor shall 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. The Contractor shall 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

The Contractor shall pay for covered services, including prescription drugs, received by a beneficiary from providers to treat emergency psychiatric conditions, 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

The Contractor shall 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

The Contractor shall implement a Quality Management Program in accordance with Title 9, CCR, Section 1810.440 and Appendix A (consisting of three pages)

and Appendix B (consisting of two pages), which are incorporated herein by reference, for evaluating the appropriateness and quality of the covered services provided to beneficiaries. References to the mental health plan (MHP) in Appendices A and B are references to the Contractor. The Contractor shall provide the Department with reports generated through the Quality Management Program on request.

The Contractor shall 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.

The Contractor shall provide the Department with information on the design, progress and outcome of the study of Latino access if required by Exhibit A, Attachment 1, Section F, of Contract No. 02-72044-000 upon request. If the Contractor was required to complete this study and has not completed the study, the Contractor may elect to continue the study beyond June 30, 2004. If the Contractor makes this election, the Contractor shall initiate the study prior to January 1, 2004 and shall notify the Department of the Contractor's intent to conduct an extended study. If the Contractor does not make this election, the Contractor shall complete the study by June 30, 2004.

G. Beneficiary Records

The Contractor shall maintain at a site or sites designated by the Contractor for each beneficiary who has received services a legible record kept in detail consistent with good professional practice and with Appendix C (consisting of three pages), which is incorporated herein by reference, that permits effective quality management processes and external operational audit processes, and that facilitates an adequate system for follow-up treatment. References to the client in Appendix C are references to beneficiaries who have received services through the Contractor. If a beneficiary receives only psychiatric inpatient hospital services, the Contractor need not maintain a record for the beneficiary in addition to the record maintained by the facility, provided the Contractor and appropriate oversight entities have access to the facility's record as provided in Exhibit E, Section 6, Item D.g.

H. Review Assistance

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

The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with Title 9, CCR, Section 1810.370. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. Pursuant to the exemption under Section 1810.110(c), Section 1810.370(a)(4)(A) shall not apply. Pursuant to the exemption under Section 1810.110(c), the Contractor shall ensure that, notwithstanding the covered diagnoses in Section 1830.205(b)(1), the MOU with the Medi-Cal managed care plan provides for the delivery of specialty mental health services to beneficiaries of the Medi-Cal managed care plan with any diagnosis for which specialty mental health services are appropriate. Specialty mental health services for diagnoses not covered by Section 1830.205(b)(1) may be provided by either the Contractor or the Medi-Cal managed care plan.

K. Cultural Competence Plan

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

L. Certification of Organizational Providers

The Contractor shall certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Appendix D (consisting of 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 Appendix 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.

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

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

N. Third-Party Tort and Casualty Liability Insurance

The Contractor shall make no claim for recovery of the value of covered services rendered to a beneficiary when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance including workers' compensation awards and uninsured motorists coverage. The Contractor 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

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

P. Financial Report

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

Q. Books and Records

The Contractor shall maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records 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

The Contractor shall comply with policy letters issued by the Department to all Mental Health Plans as defined in Title 9, CCR, Section 1810.226. Policy letters 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

The Contractor shall 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 L. 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

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

V. Encounter Data Reporting

The Contractor shall 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). The Contractor shall 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. The Contractor shall 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 Appendix 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

Except as provided in Section CC, the Contractor shall 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 Exhibit B, rather than in accordance with Title 9, CCR, Division 1, Chapter 11, Subchapter 4.

X. Psychiatric Inpatient Hospital Services Claims Processing

The Contractor shall 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

The Contractor shall 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 Table 1 in Exhibit B at the lowest adult or child level, as applicable.

Z. Beneficiary Brochure and Provider Lists

The Contractor shall 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.

The Contractor shall 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.

AA. Compliance with the Requirements of Emily Q v. Bontá

The Contractor shall comply with the provisions of the Final Judgment and Preliminary Injunction issued May 11, 2001, in the case of Emily Q. v. Bontá,

Case No. CV 98-4181 AHM (AIJx), United States District Court, Central District of California, that apply to the Contractor as determined by the Department.

BB. Reports Required by the Centers for Medicare and Medicaid Services

The Contractor shall report to the Department no later than October 1, 2003, the number of children by category who voluntarily changed outpatient mental health providers during fiscal year 2002-03.

The Contractor shall report to the Department by October 1, 2003, the number of complaints raised to the Contractor through the Contractor's beneficiary problem resolution processes by category of children with special health care needs, by type of problem resolution process used (complaint process or grievance process) during fiscal year 2002-03. The report will include the issue and disposition of each complaint, unless more than 25 complaints were filed. If more than 25 complaints were filed, the report will include by the type of issues raised, the number filed under each type and the disposition by the following categories: granted in full, granted in part, denied.

Children with special health care needs are Medi-Cal beneficiaries under the age of 19 who meet the following criteria:

1. In Medi-Cal aid codes 20, 23, 24, 26, 27, 28, 6A, 60, 63, 64, 65, 66, 67, 68, 6C (Medi-Cal eligibility based on eligibility for Supplemental Security Income/Blind/Disabled)

2. In Medi-Cal aid codes 4K, 4C, 42, 5K, 40, 45 (Medi-Cal eligibility based on eligibility for Foster Care)

3. In Medi-Cal aid codes 03, 04 (Medi-Cal eligibility based on eligibility for Adoption Assistance programs)

4. In Medi-Cal aid codes 6V, 6W, 6X, 6Y (Medi-Cal beneficiaries enrolled in a Home and Community Based Services Model waiver)

5. Receiving services from the California Children's Services program as identified by the local CCS program, if the local CCS program is willing to provide the information, or by the beneficiary listing available to the Contractor on the Contractor's secured website at the Department. If both method are available to the Contractor, the Contractor may select the identification method. If another method of identification becomes available, the Department will notify the Contractor through a letter to all county mental health directors.

CC. Submission of Claims for Therapeutic Behavioral Services

The Contractor shall submit claims for therapeutic behavioral services through Short-Doyle/Medi-Cal claims processing system to obtain federal financial

participation, consistent with DMH Letter No. 99-03. These services are not included in the case rate payments.

DD. Requirements for Day Treatment Intensive and Day Rehabilitation

1. Authorization and Service Requirements

The Contractor shall implement the following policies and procedures pertaining to day treatment intensive and day rehabilitation, as defined in Title 9, CCR, Sections 1810.213 and 1810.212 respectively, no later than September 1, 2003:

The Contractor shall require providers to request an initial mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, from the Contractor for day treatment intensive and for day rehabilitation. Provider as used in this section includes Contractor staff. The Contractor shall require providers to request MHP payment authorization from the Contractor in advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week. The Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive at least every three months and day rehabilitation at least every six months. The Contractor's MHP payment authorization function must meet the criteria of Title 9, CCR, Section 1830.215, except that the Contractor shall not delegate the MHP payment authorization function to providers. In the event that the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization function does not include Contractor staff involved in providing day treatment intensive or day rehabilitation.

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

In addition to meeting the requirements of Title 9, CCR, Sections 1840.318, 1840.328, 1840.330, 1840.350, and 1840.352, the Contractor shall require

that providers of day treatment intensive and day include the following minimum service components in day treatment intensive or day rehabilitation:

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

b. A therapeutic milieu, which means a therapeutic program that is structured by the service components described in subsections a. and b. below with specific activities being performed by identified staff; takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program); includes staff and activities that teach, model and reinforce constructive interactions; includes peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

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

   1) Day rehabilitation must include:

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

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

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

2). Day treatment intensive must include:

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

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

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

treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.

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

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

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

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

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

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

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

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

i. A written program description for day treatment intensive and day rehabilitation. Each provider of these services, including Contractor staff, shall be required to develop and maintain this program description. The written program description must describe the specific activities of the service and reflect each of the required components of the services described in this section. The Contractor shall review the written program description for compliance with this section for individual and group providers that begin delivering day treatment intensive or day rehabilitation on or after September 1, 2003 prior to the date the provider begins delivering day treatment intensive or day rehabilitation. The Contractor shall review the written program description for compliance with this section for individual and group providers that were providing day treatment intensive or day rehabilitation prior to September 1, 2003 no later than June 30, 2004.

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

3. Implementation of Authorization Requirements

The Contractor shall implement these MHP payment authorization requirements effective September 1, 2003, for beneficiaries whose initial referral for day treatment intensive or day rehabilitation occurs on or after September 1, 2003. For beneficiaries who were receiving day treatment intensive or day rehabilitation prior to September 1, 2003, the Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive no later than November 30, 2003 and day rehabilitation no later than March 31, 2004. The Contractor shall require providers to follow the same timelines for MHP payment authorization of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic

behavioral services as described in DMH Letter No. 99-03, provided on the same day as day treatment intensive or day rehabilitation.

EE. MHP Payment Authorization Requirements for Therapeutic Behavioral Service

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

Effective September 1, 2003, the Contractor shall require providers to request initial and on-going mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, for TBS as described below. The Contractor shall not delegate the authorization function to providers. Provider as used in this section includes Contractor staff. In the event that the Contractor is the TBS provider, the Contractor shall assure that the authorization process does not include staff involved in providing TBS. The Contractor shall require providers to submit MHP payment authorization requests prior to the end of the specified hours or days in the current authorization period and shall make timely decisions on MHP payment authorization requests to ensure there is no break in medically necessary services to the beneficiary.

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

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

1. General Authorization Requirements

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

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

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

d. The Contractor shall issue a decision on an MHP payment authorization request for TBS no later than 14 calendar days of receipt of the request.

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

2. Initial Authorization

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

3. Reauthorization

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

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

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

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

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

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

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

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

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

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

c. When the provider's initial request for MHP payment authorization includes a completed TBS assessment and TBS client plan that meets the requirements of subsection b.1) through 7), the Contractor may authorize TBS services consistent with the limits of this section, i.e., an initial MHP payment authorization request that covers direct one-to-one TBS that are fully supported by an assessment and TBS client plan may be approved for 60 days or 120 hours, whichever is less.

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

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

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

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

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

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

4. Implementation of Authorization Requirements

The Contractor shall implement these MHP payment authorization requirements effective September 1, 2003, for beneficiaries whose initial referral for TBS occurs on or after September 1, 2003. For beneficiaries who were receiving direct one-to-one TBS or who had been referred to a provider that would provide both the initial assessment of the need for TBS and direct one-to-one TBS prior to September 1, 2003, the Contractor shall complete the reauthorization for on-going TBS by November 1, 2003.

FF. Program Integrity Requirements

Effective August 13, 2003 the Contractor shall initiate the process for compliance with Title 42, Code of Federal Regulations (CFR), Section 438.608. The Contractor shall provide the Department will a written statement of the Contractor's progress in implementing the requirement no later than October 15,

2003 and an update on progress on January 15, 2004 and April 15, 2004. Title 42, CFR, Section 438.608, in which the Contractor is a PIHP (Prepaid Inpatient Health Plan), provides:

Sec. 438.608 Program integrity requirements.

(a) General requirement. The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.
(b) Specific requirements. The arrangements or procedures must include the following:
(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.
(3) Effective training and education for the compliance officer and the organization's employees.
(4) Effective lines of communication between the compliance officer and the organization's employees.
(5) Enforcement of standards through well-publicized disciplinary guidelines.
(6) Provision for internal monitoring and auditing.
(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

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

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.

Documentation Standards For Client Records

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

A. Assessments

1. The following areas 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 and/or specific 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 and family therapist 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)
- Day Treatment Intensive, effective September 1, 2003

c. Weekly

- Day Treatment Intensive, effective July 1, 2003 through August 31, 2003
- Effective September 1, 2003, Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.
- Day Rehabilitation
- Adult Residential

d. Other

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

Provider Certification by the Contractor or the Department

As a part of the organizational provider certification requirements in Exhibit A, Attachment 1, Section L, and Exhibit E, Section 5, Item 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.

11. For organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with Exhibit A, Attachment 1, Section DD, paragraphs . This requirement applies to new providers beginning September 1, 2003 and providers being recertified on or after March 1, 2004.

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

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

When an on site review of an organizational provider would not otherwise be required and the provider provides day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Exhibit A, Attachment 1, Sections DD, paragraphs. The Contractor must complete this review for new organizational providers for which on-site review is not required beginning September 1, 2003 and for any other organizational providers for which on-site review is not required by June 30, 2004.

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:

1. The provider makes major staffing changes.

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

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

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

5. There is a change of ownership or location.

6. There are complaints regarding the provider.

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

Required Managed Care Encounter Data Reporting Elements

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	

EXHIBIT B
PAYMENT PROVISIONS

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

2. Budget Contingency Clauses

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

   B. State Budget:

      It is mutually agreed that if the Budget Act of the current year does not appropriate sufficient funds for the program, this contract will be void and of no further force and effect. In such an event, the State 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.

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

3. Prompt Payment Clause

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

4. Amounts Payable

   The total amount payable for the 2003-2004 Fiscal Year ending June 30, 2004 is $8,357,680. Of the total amount payable for the 2003-2004 Fiscal Year, $5,856,000 is for mental health pharmacy and related laboratory services. The amount payable is an interim amount only and is subject to the development of the allocation amount for the 2003-2004

Fiscal Year pursuant to Item 7. Any requirement of performance by the Department and the Contractor for this period will be dependent upon the availability of future appropriations by the Legislature for the purpose of this contract. The services shall be provided at the times required by this contract.

5. Payment to the Contractor

The Contractor will receive a single payment for the amount payable under Item 4, less the amount attributed to pharmacy and related laboratory services, 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 Fiscal Year, whichever is later. The Contractor will receive equal quarterly payments of the amount payable under Item 4 for pharmacy and related laboratory services within 30 days of the end of the quarters ending September 30, 2002, December 31, 2002, March 31, 2003, and June 30, 2003.

6. Payment in Full

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

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

7. 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 2002-2003 will be an amount based on trends in pharmacy and laboratory cost developed from HPSM, fee-for-service Medi-Cal and Contractor cost data.

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.

8. Renegotiation or Adjustment of Allocation Amount

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

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

9. 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.

10. Federal Financial Participation—Case Rates

FFP for covered services, other than pharmacy and related laboratory services and therapeutic behavioral services as described in Exhibit A, Attachment 1, Section CC, 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 Exhibit A, Attachment 1, 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 therapeutic behavioral services as described in Exhibit A, Attachment 1, Section CC, 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 and, effective July 30, 2001, therapeutic behavioral services, are not 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 Exhibit A, Attachment 1, 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.

11. Federal Financial Participation—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 services included in the case rate 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 Department will periodically audit Short-Doyle/Medi-Cal paid claims for beneficiaries receiving services from providers 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.

12. Case Rates

Table 1, below, displays the fiscal year 2003-2004 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 1
Fiscal Year 2003-2004 Case Rates
(FFP and State Match)

Service Level	FY 2003-04 Monthly Case Rates
Adult – Intensive Services	$3376.74
Adult – Regional Services	$1033.07
Adult – Provider Network	$215.66
Child – Intensive Services	$3030.10
Child – Regional Services	$1220.95
Child – Provider Network	$234.80

13. Federal Financial Participation—Pharmacy and Laboratory Services

FFP for pharmacy and laboratory services shall be paid in accordance with Exhibit A, Attachment 1, Section W.

EXHIBIT D
SPECIAL PROVISIONS

1. Fulfillment of Obligation

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

2. Amendment of Contract

Should either party during the life of this contract desire a change in this contract, such change will be proposed in writing to the other party. The other party 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.

3. Contract Disputes

Should a dispute arise between the Contractor and the Department relating to performance under this contract other than disputes governed by a dispute resolution process in Chapter 11 of Division 1, Title 9, 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.

4. 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.

5. 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:

State Dept. of Mental Health Services
Technical Assistance and Training
Systems of Care Division
1600 Ninth Street, Room 100
Sacramento, CA 95814

San Mateo County Mental Health
225 West 37th Avenue
San Mateo, CA 94403

6. Confidentiality

A. 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.

B. 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.

C. 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.

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

7. Nondiscrimination

A. Consistent with the requirements of applicable federal or state law, the Contractor 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.

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

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

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

8. Patients' Rights

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

9. 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.

10. Waiver of Default

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

EXHIBIT E
ADDITIONAL PROVISIONS

SECTION 1 – GENERAL AUTHORITY

This contract is entered into in accordance with the provisions of Section 5719.5 and Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions (W&I) Code.

SECTION 2 – 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.

SECTION 3 – 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, regulations, and agreements. 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.

SECTION 4 – TERM AND TERMINATION

A. 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.

B. Contract Termination

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

C. Mandatory Termination

The Department shall immediately terminate this contract in the event that the Director determines that there is an immediate threat to the health and safety of beneficiaries. The department shall terminate this contract in the event that the Secretary, HHS, determines that the contract does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. Terminations under this section will be in accordance with Title 9, CCR, Section 1810.325.

D. 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.

SECTION 5 - HIPAA BUSINESS ASSOCIATE AGREEMENT

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

as the "Privacy Rule." Terms used but not otherwise defined in this section shall have the same meaning as those terms are used in the Privacy Rule.

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

A. Use and Disclosure of Protected Health Information

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

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

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

B. Further Disclosure of PHI

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

C. Safeguard of PHI

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

D. Unauthorized Use or Disclosure of PHI

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

E. Mitigation of Disallowed Uses and Disclosures

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

F. Agents and Subcontractors of the Business Associate

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

G. Access to PHI

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

H. Amendment(s) to PHI

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

I. Documentation of Uses and Disclosures

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

J. Accounting of Disclosure

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

individual for an accounting of disclosures of PHI in accordance with Title 45, CFR, Section 164.528.

K. Records Available to the Department and Secretary of HHS

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

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

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

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

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

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

M. Amendments to Section

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

N. Material Breach

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

O. Survival

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

P Interpretation

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

SECTION 6 – DUTIES OF THE STATE

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

A. Payment for Services

Pay the appropriate payments set forth in Exhibit B.

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 Exhibit A, Attachment 1, Item 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 Exhibit A, Attachment 1, Item 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 Exhibit A, Attachment 1, Appendix D. This certification shall be prior to the date on which the Contractor begins to deliver services under this contract at these sites and once every 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.

SECTION 7 – SUBCONTRACTS

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

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

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

D. Each subcontract must contain:

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

b. Specification of the services to be provided.

c. Specification that the subcontract 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 Exhibit D, Section 7.

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

g. The subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination or copying by the Department, 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.