COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

http://dmh.co.la.ca.us

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: Phone: (213) 738-4601
Fax: (213) 386-1297

June 17, 2004

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

71 JUN 29 2004

Violet Varona-Lukens
VIOLET VARONA-LUKENS
EXECUTIVE OFFICER

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL TO RENEW MENTAL HEALTH SERVICES PLAN AGREEMENT (CONTRACT NO. 04-74032-000) WITH THE STATE DEPARTMENT OF MENTAL HEALTH FOR MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES FOR FISCAL YEAR 2004-2005 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of Mental Health or his designee to enter into an Agreement, substantially similar to the Attachment, with the State Department of Mental Health (SDMH) in accordance with the provisions of Part 2.5 of Division 5 of the Welfare and Institutions Code. This Agreement will allow for the uninterrupted provision of specialty mental health services to impacted clients in all Supervisorial Districts. The State allocation has been included in the Department of Mental Health's (DMH) Proposed Budget for Fiscal Year (FY) 2004-2005. The Agreement will be effective from July 1, 2004 until June 30, 2005.

2. Instruct the Director of Mental Health to submit all necessary documents to SDMH and accept State General Fund (SGF) dollars allocated to Los Angeles County for the local operation of Medi-Cal Specialty Mental Health Services. The total State allocation for FY 2004-2005 is $67,456,432.

3. Instruct the Director of Mental Health to advise the Board of any significant changes to the program or State requirements that would impact Medi-Cal Specialty Mental Health Services or the ability to carry out the Agreement.

4. Delegate authority to the Director of Mental Health or his designee to prepare, sign, and execute future Amendments to Contract No. 04-74032-000 for FY 2004-2005 provided that: 1) approval of County Counsel and the Chief Administrative Officer or his designee is obtained prior to any such Amendment; and 2) the Director of Mental Health shall notify the Board of Supervisors of Agreement changes in writing within 30 days after execution of each Amendment.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Board approval is requested to continue administration of Specialty Mental Health Services for Medi-Cal eligible residents of Los Angeles County as part of DMH's Local Mental Health Plan (LMHP).

Contract No. 03-73029-000, between the State of California and DMH, will terminate on June 30, 2004. Contract No. 04-74032-000 shall provide funding for FY 2004-2005 for Specialty Mental Health Services for Medi-Cal eligible residents in Los Angeles County.

Implementation of Strategic Plan Goals

The recommended Board actions are consistent with the County's Organizational Goal #4, "Fiscal Responsibility" within the Countywide Strategic Plan. Approval of these actions will provide for continued funding for Specialty Mental Health Services for FY 2004-2005.

FISCAL IMPACT/FINANCING

There is no impact on net County cost. The State Allocation is $67,456,432. The FY 2004-2005 Proposed Budget is overstated by $624,568, which will be addressed in the supplemental budget process.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Participation in the State Medi-Cal Consolidation Program will continue to be funded by SGF dollars for professional services rendered by psychiatrists, psychologists, Licensed Clinical Social Workers, Marriage and Family Therapists, and Registered Nurses with master's degrees within their area of practice and for acute psychiatric hospital inpatient services with contracted Fee-For-Service (FFS) providers.

The Medi-Cal Consolidation Program continues to foster a closer working relationship and collaboration between departments, such as Probation and Children and Family Services, which utilize Specialty Mental Health Providers for professional and hospital inpatient services to children and adolescents eligible under Medi-Cal.

SDMH has submitted an Agreement (see Attachment) for signature by the County of Los Angeles DMH. It outlines the terms and conditions for continued funding and operations of the LMHP by Los Angeles County.

The Chief Administrative Office, County Counsel and DMH's Fiscal and Program Administrations have approved the proposed actions.

CONTRACTING PROCESS

State regulations require a contractual agreement between SDMH and County departments in order to continue funding the LMHP under the State Medi-Cal Consolidation Program. The Agreement is entered in accordance with the provisions of Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions Code.

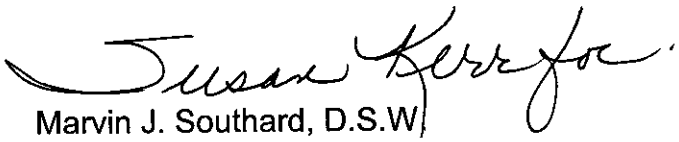
IMPACT ON CURRENT SERVICES

Renewal of this Agreement will provide continued funding to reimburse FFS mental health providers for Specialty Mental Health Services and contracted FFS hospital acute inpatient services provided to Los Angeles County's Medi-Cal beneficiaries.

CONCLUSION

The Department of Mental Health will need one (1) copy of the Board's action. It is requested that the Executive Officer of the Board notifies the Department of Mental Health's Contracts Development and Administration Division at (213) 738-4684 when this document is available.

Respectfully submitted,



Marvin J. Southard, D.S.W.
Director of Mental Health

MJS:MY:RK:OV

Attachment

c: Chief Administrative Officer
County Counsel
Auditor-Controller
Chairperson, Mental Health Commission

State of California

STANDARD AGREEMENT

STD. 213 (NEW 02/98)

Attachment

Agreement Number	Amendment Nbr.
04-74032-000	

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:

Los Angeles County Mental Health

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

3. The maximum amount of this agreement is: **$67,456,432.00**
Sixty Seven Million Four Hundred Fifty Six Thousand Four Hundred Thirty Two Dollars And

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

Exhibit A - Scope of Work	Page(s)	46
Exhibit B - Budget Detail and Payment Provision	Page(s)	3
* Exhibit C - General Terms and Conditions	Form:	GTC 304 Dated 3/1/2004
Exhibit D - Special Terms and Conditions	Page(s)	5
Exhibit E - Additional Provision	Page(s)	79

*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.)*

Los Angeles County Mental Health

BY *(Authorized Signature)* DATE SIGNED

PRINTED NAME AND TITLE OF PERSON SIGNING

Marvin Southard, DSW, Director

ADDRESS **550 South Vermont, 12th Floor**
Los Angeles, CA 90020

STATE OF CALIFORNIA

AGENCY NAME

Department of Mental Health

BY *Authorized Signature* DATE SIGNED

PRINTED NAME AND TITLE OF PERSON SIGNING

William A. Avritt, 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, 2004 – JUNE 30, 2005

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

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

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

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

Department of Mental Health County Operations Eddie Gabriel (916) 654-3263 Fax: (916) 654-5591	Los Angeles County Mental Health Marvin Southard, DSW, Director (213) 738-2756 (213) 386-1297

Direct all inquiries to:

Department of Mental Health County Operations Section 1600 9th Street, Room 100 Sacramento, CA 95814	Los Angeles County Mental Health Marvin Southard, DSW, Director 550 South Vermont, 12th Floor Los Angeles, CA 90020

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

SERVICE DELIVERY, ADMINISTRATIVE AND OPERATIONAL REQUIREMENTS

A. Provision of Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Availability and Accessibility of Service

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

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

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

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

C. Emergency Psychiatric Condition Reimbursement

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

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

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

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

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

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

D. Organizational and Administrative Capability

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

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

2. Beneficiary problem resolution processes.

3. Provider problem resolution and appeal processes.

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

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

E. 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, including overutilization and underutilization of services, and quality of the covered services provided to beneficiaries. References to the mental health plan (MHP) in Appendices A and B are references to the Contractor. The Contractor shall provide the Department with reports generated through the Quality Management Program on request. The Contractor shall also submit timely claims to the Department that are certified in accordance with Title 9, CCR, Section 1840.112 to enable the Department to measure the Contractor's performance.

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

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

F. Beneficiary Records

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

G. Review Assistance

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

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

H. Implementation Plan

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

I. Memorandum of 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.

J. Cultural Competence Plan

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

K. Provider Selection and Certification

1. Provider Selection and Certification—General

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

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

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

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

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

2. Certification of Organizational Providers

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

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

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

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

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

L. Recovery from Other Sources or Providers

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

M. Third-Party Tort and Casualty Liability Insurance

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

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

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

   a. Beneficiary name.

   b. Full 14 digit Medi-Cal number.

   c. Social Security Number.

d. Date of birth.

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

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

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

N. Financial Resources

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

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

O. Financial Report

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

P. Books and Records

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

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

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

Q. Transfer of Care

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

R. Department Policy Letters

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

S. Delegation

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

T. Fair Hearings

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

U. Crosswalk between Provider Coding System

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

V. Beneficiary Brochure and Provider Lists

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

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

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

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

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

W. Compliance with the Requirements of 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.

X. Requirements for Day Treatment Intensive and Day Rehabilitation

1. Authorization and Service Requirements

The Contractor shall require providers to request an initial mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, 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 shall meet the criteria of Exhibit A, Attachment 2, Section B, except that the Contractor shall not delegate the MHP payment authorization function to providers. In the event that the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization

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

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

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

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

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

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

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

1) Day rehabilitation shall include:

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

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

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

2). Day treatment intensive shall include:

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

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

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

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

d. A detailed weekly schedule that is available to clients and, as appropriate, to their families, 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 shall specify the program staff, their qualifications, and the scope of their responsibilities.

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

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

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

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

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

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

h. At least one contact (face-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 shall describe the specific activities of the service and reflect each of the required components of the services described in this section. The Contractor shall review the written program description for compliance with this section for individual and group providers that begin delivering day treatment intensive or day rehabilitation prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

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

3. Authorization Requirements for Related Services

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

Y. MHP Payment Authorization Requirements for Therapeutic Behavioral Service

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

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

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

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

1. General Authorization Requirements

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

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

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

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

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

2. Initial Authorization

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

3. Reauthorization

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

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

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

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

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

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

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

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

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

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

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

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.

Z. Program Integrity Requirements

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

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

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

RECONCILIATION WITH FEDERAL REGULATIONS

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

A. Notification of Beneficiaries

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

B. MHP Payment Authorization

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

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

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

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

   c. Consult with the requesting provider when appropriate.

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

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

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

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

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

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

C. Beneficiary Problem Resolution Processes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The availability of assistance in filing;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Fair Hearing and Notice of Action

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

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

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

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

4. Notwithstanding subsection (d) of Title 9, CCR, Section 1850.210, the Contractor shall include information regarding the beneficiary's right to request an expedited fair hearing in accordance with Title 42, CFR, Section 431:244(f)(3) on the notice of action.

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

E. Post-Stabilization Care Services

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

   a. Are prior authorized by the Contractor

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

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

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

      (2) The Contractor cannot be contacted; or

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

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

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

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

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

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

   d. The beneficiary is discharged.

F. Emergency Psychiatric Condition Reimbursement

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

ADDITIONAL REQUIREMENTS BASED ON FEDERAL REGULATIONS

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

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

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

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

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

6. The Contractor shall obtain prior approval from the Department if the Contractor intends to refuse to provide or arrange and pay for a covered service because the Contractor objects to the service on moral or religious grounds. The Department shall approve the request only if the State is able to provide adequate access to the service or services the Contractor does not intend to provide. If the Department does not approve the request, the Contractor may terminate the contract in accordance with Exhibit E, Section 4.B.

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

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

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

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

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

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

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

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

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

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

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

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

Quality Improvement Program

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

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

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

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

1. Monitoring the service delivery capacity of the MHP:

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

2. Monitoring the accessibility of services:

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

3. Monitoring beneficiary satisfaction

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

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

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

- Providers, consumers and family members shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice 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 shall work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries
     - When appropriate, the MHP shall exchange information in an effective and timely manner with other agencies used by its beneficiaries
     - The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans

6. Monitoring provider appeals

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

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

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

Utilization Management Program

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

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

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

b) Documentation shall verify that the MHP:
   i) Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation
   ii) Approves the delegated entity's UM program annually
   iii) Evaluates annually whether the delegated activities are being conducted in accordance with the State and MHP standards, and
   iv) Has prioritized and addressed with the delegated entity those opportunities identified for improvement.

Documentation Standards For Client Records

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

A. Assessments

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

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

2. Timeliness/Frequency Standard for Assessment

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

B. Client Plans

1. Client Plans shall:

   - have specific observable and/or specific quantifiable goals

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

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

2. Timeliness/Frequency of Client Plan:

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

C. Progress Notes

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

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

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

2. Timeliness/Frequency of Progress Notes:

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

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

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

c. Weekly

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

d. Other

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

Provider Certification by the Contractor or the Department

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

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

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

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

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

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

6. The organizational provider maintains client records in a manner that meets the requirements of the Contractor pursuant to Exhibit A, Attachment 1, Section F, and applicable state and federal standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) The provider makes major staffing changes.

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

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

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

e) There is a change of ownership or location.

f) There are complaints regarding the provider.

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

EXHIBIT B
PAYMENT PROVISIONS

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

2. Budget Contingency Clauses

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

   B. State Budget:

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

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

3. Prompt Payment Clause

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

4. Amounts Payable

   The total amount payable for the 2004-05 Fiscal Year ending June 30, 2005 is $67,456,432. The amount payable is an interim amount only and is subject to the development of the allocation amount for the 2004-2005 Fiscal Year pursuant to Item 7. Any requirement of performance by the Department and the Contractor for this period shall be dependent upon the availability of future appropriations by the Legislature

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

5. Payment to the Contractor

The Contractor shall receive a single payment for the full amount payable under Item 4 for the fiscal year within 60 calendar days of the determination of the amount by the Department in accordance with Title 9, California Code of Regulations (CCR), Section 1810.330, or the enactment of the State Budget for the fiscal year, whichever is later.

6. Payment in Full

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

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

7. Determination of Allocation Amount

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

8. Renegotiation or 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 shall 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 shall be retroactive to the effective date of the change authorizing the amendment.

9. Disallowances and Offsets

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

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

10. Federal Financial Participation

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

EXHIBIT D
SPECIAL PROVISIONS

1. Fulfillment of Obligation

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

2. Amendment of Contract

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

3. Contract Disputes

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

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

4. Inspection Rights

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

5. Notices

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

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

Los Angeles County Mental Health
Marvin Southard, DSW, Director
550 South Vermont, 12th Floor
Los Angeles, CA 90020

6. Confidentiality

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

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

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

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

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

7. Nondiscrimination

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

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

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

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

8. Patients' Rights

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

9. Relationship of the Parties

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

10. Waiver of Default

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

11. Additional Contract Provisions

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

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

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

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

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

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

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

EXHIBIT E
ADDITIONAL PROVISIONS

SECTION 1 – GENERAL AUTHORITY

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

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

SECTION 2 – DEFINITIONS

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

A. "Beneficiary" means any Medi-Cal beneficiary whose county of responsibility on the Medi-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 Los Angeles County Mental Health.

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

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

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

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

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

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

1. A danger to self or others, or

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

I. "Facility" means any premises:

1. Owned, leased, used or operated directly or indirectly by or for the Los Angeles County Mental Health or its affiliates for purposes related to this contract, or

2. Maintained by a provider to provide covered services on behalf of the Los Angeles County Mental Health.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3 – GENERAL PROVISIONS

A. Governing Authorities

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

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

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

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

Title 42, Code of Federal Regulations (CFR);

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

Title 42, United States Code;

Title VI of the Civil Rights Act of 1964;

Title IX of the Education Amendments of 1972;

Age Discrimination Act of 1975;

Rehabilitation Act of 1973;

Titles II and III of the Americans with Disabilities Act;

All other applicable laws and regulations; and

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

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

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

SECTION 4 – TERM AND TERMINATION

A. Contract Renewal

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

B. Contract Termination

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

C. Mandatory Termination

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

Terminations under this section shall be in accordance with Title 9, CCR, Section 1810.325.

D. Termination of Obligations

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

SECTION 5 - HIPAA BUSINESS ASSOCIATE AGREEMENT

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

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

A. Use and Disclosure of Protected Health Information

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

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

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

B. Further Disclosure of PHI

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

C. Safeguard of PHI

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

D. Unauthorized Use or Disclosure of PHI

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

E. Mitigation of Disallowed Uses and Disclosures

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

F. Agents and Subcontractors of the Business Associate

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

G. Access to PHI

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

H. Amendment(s) to PHI

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 shall terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

O. Survival

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

P Interpretation

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

SECTION 6– DUTIES OF THE STATE

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

A. Payment for Services

Pay the appropriate payments set forth in Exhibit B.

B. Reviews

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

C. Monitoring for Compliance

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

D. Approval Process

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

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

3. The Department shall act promptly to review requests from the Contractor for approval of subcontracts with providers that meet the conditions described in Title 9, CCR, Section 1810.438. The Department shall act to approve or disapprove the reimbursement and related claiming and cost reporting issues included in the subcontract within 60 days of receipt of a request from the Contractor. If the

Department disapproves the request, the Department shall provide the Contractor with the reasons for disapproval.

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

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

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

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

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

F. Development and Distribution of Informing Materials

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

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

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

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

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

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

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

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

G. Sanctions

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

H. Notification

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

I. Performance Measurement

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

J. Data Certification

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

SECTION 7 – SUBCONTRACTS

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

B. All subcontracts must be in writing.

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

D. Each subcontract must contain:

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

b. Specification of the services to be provided.

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

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

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

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

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

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

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

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

STATE REGULATIONS CROSS-REFERENCED IN CONTRACT

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

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

1810.212. Day Rehabilitation.

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

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

1810.213. Day Treatment Intensive.

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

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

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

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

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

1810.216. Emergency Psychiatric Condition.

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

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

1810.216.1. Fair Hearing.

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

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

1810.218.2. Group Provider.

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

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

1810.222. Individual Provider.

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

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

1810.223. Licensed Mental Health Professional.

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

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

1810.226. Mental Health Plan (MHP).

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

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

1810.227. Mental Health Services.

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

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

1810.229. MHP Payment Authorization.

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

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

1810.231. Organizational Provider.

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

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

1810.237.1. Psychiatric Inpatient Hospital Professional Services.

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

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

1810.239. Psychiatric Nursing Facility Services.

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

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

1810.247. Specialty Mental Health Services.

"Specialty Mental Health Services" means:

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

(b) Psychiatric Inpatient Hospital Services;

(c) Targeted Case Management;

(d) Psychiatrist Services;

(e) Psychologist Services;

(f) EPSDT Supplemental Specialty Mental Health Services; and

(g) Psychiatric Nursing Facility Services.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14021.3, 14021.4, 14132, and 14684, Welfare and Institutions Code.

1810.253. Urgent Condition.

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

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

1810.254. Waivered/Registered Professional.

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

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

Article 3. Administration

1810.310. Implementation Plan.

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

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

(2) A description of the process for:

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

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

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

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

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

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

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

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

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

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

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

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

(b) The department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to applicant MHP entities within 60 calendar days of the receipt of the Implementation Plan.

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

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

1810.320. Contract Renewal.

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

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

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

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

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

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

1810.325. Contract Termination.

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

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

(c) The department shall terminate its contract with an MHP that the Secretary, Health and Human Services has determined does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act. The department shall deliver written notice of termination to the MHP at least 60 calendar days prior to the proposed effective date of termination.

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

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

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

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

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

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

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

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

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

1810.330. Allocation of State Funds to MHPs.

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

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

1810.345. Scope of Covered Specialty Mental Health Services.

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

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

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

1810.350. Scope of Covered Psychiatric Inpatient Hospital Services.

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

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

(1) Routine hospital services and

(2) All hospital-based ancillary services.

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

(1) Routine hospital services,

(2) All hospital-based ancillary services, and

(3) Psychiatric inpatient hospital professional services.

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

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

1810.360. Notification of Beneficiaries.

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

(1) The date the MHP will begin operation.

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

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

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

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

(1) A description of the services available.

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

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

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

1810.365. Beneficiary Billing.

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

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

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

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

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

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

1810.370. MOUs with Medi-Cal Managed Care Plans.

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

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

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

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

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

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

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

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

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

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

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

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

(c) When enrollment in a Medi-Cal managed care plan in any county is 2000 beneficiaries or less, the department shall, at the request of the MHP or the Medi-Cal managed care plan, grant a waiver from the requirements of this section provided both plans provide assurance that beneficiary care will be coordinated in compliance with Section 1810.415.

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

1810.380. State Oversight.

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

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

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

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

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

(5) Monitor denials of MHP payment authorizations.

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

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

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

(3) Impose civil penalties pursuant to Section 1810.385.

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

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

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

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

(1) A description of the violation.

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

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

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

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

1810.385. Civil Penalties.

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

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

(1) The provisions of Section 1810.350, "Notification of Beneficiaries", Section 1850.205, "Beneficiary Problem Resolution Processes", Section 1850.210, "Fair Hearing and Notice of Action", and Section 1850.215, "Medical Assistance for Beneficiary Pending Fair Hearing Decision".

(A) First violation: $1,000.

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

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

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

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

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

(A) First violation: $500.

(B) Second violation: $1,000.

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

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

(A) First violation: $500.

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

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

(A) First violation: $1,000.

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

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

NOTE: Authority: Sections 5775(e)(1) and 14680, Welfare and Institutions Code.
Reference: Sections 5775(e)(1) and 5777, Welfare and Institutions Code.

Article 4. Standards

1810.405. Access Standards for Specialty Mental Health Services.

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

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

(1) Physical health care providers

(2) Schools

(3) County welfare departments

(4) Other MHPs.

(5) Conservators, guardians, or family members.

(6) Law enforcement agencies.

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

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

(e) At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

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

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

1810.410 Cultural and Linguistic Requirements.

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

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

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

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

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

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

(c) The department shall establish timelines for the submission and review of the Cultural Competence Plan described in subsection (b) either as a component of the Implementation Plan process described in Section 1810.310 or as a term of the contract between the MHP and the department. The MHP shall submit the Cultural Competence Plan to the department for review and approval in accordance with these timelines. The MHP shall update the Cultural Competence Plan and submit these updates to the department for review and approval annually.

(d) Each MHP shall provide:

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

(2) Interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points of

contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

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

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

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

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

(f) Definitions:

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

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

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

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

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

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

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

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

(2) Maintain a safe facility.

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

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

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

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

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

(1) Possess the necessary license to operate.

(2) Provide for appropriate supervision of staff.

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

(4) Possess appropriate liability insurance.

(5) Maintain a safe facility.

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

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

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

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

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

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

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

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

1810.438 Alternative Contracts between MHPs and Providers.

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

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

(1) The proposed contract terms concerning reimbursement,

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

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

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

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

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

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

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

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

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

1810.440. MHP Quality Management Programs.

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

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

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

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

(A) Providers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

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

(D) Tic Disorders

(E) Elimination Disorders

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

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

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

(I) Schizophrenia and Other Psychotic Disorders

(J) Mood Disorders

(K) Anxiety Disorders

(L) Somatoform Disorders

(M) Dissociative Disorders

(N) Eating Disorders

(O) Intermittent Explosive Disorder

(P) Pyromania

(Q) Adjustment Disorders

(R) Personality Disorders

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

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

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

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

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

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

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

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

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

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

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

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

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

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

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

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

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

1820.215. MHP Payment Authorization - General Provisions.

(a) The MHP payment authorization shall be determined for

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

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

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

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

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

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

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

(1) A natural disaster which has:

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

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

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

(A) Negligence by employees.

(B) Misunderstanding of program requirements.

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

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

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

1820.220. MHP Payment Authorization by a Point of Authorization.

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

(1) The planned admission of a beneficiary.

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

(3) Upon discharge.

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

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

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

(1) Prior to a planned admission.

(2) Within 14 calendar days after :

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

(B) Discharge.

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

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

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

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

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

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

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

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

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

(1) by a physician, or

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

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

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

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

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

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

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

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

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

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

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

2. Within 14 calendar days after a beneficiary has received 99 continuous calendar days of psychiatric inpatient hospital services

(4) Requests for MHP payment authorization for continued stay services shall be approved if written documentation has been provided to the MHP indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of service in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP.

(5) Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

(A) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week subject to the following requirements:

1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

(C) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage, the hospital has notified the Point of Authorization within 24 hours or as specified in the contract, prior to beginning administrative day services.

(6) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a hospital shall be approved by an MHP when necessary documentation, as specified in Section 1850.215, is submitted.

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

Reference: Sections 5777, 5778, and 14684, Welfare and Institutions Code.

1820.225. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

(a) The MHP shall not require a hospital to obtain prior MHP payment authorization for an emergency admission, whether voluntary or involuntary.

(b) The hospital providing emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in Section 1820.205, and due to a mental disorder, is:

(1) A danger to self or others, or

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

(c) The hospital providing emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within 24 hours of the time of the admission of the beneficiary to the hospital, or within the timelines specified in the contract, if applicable.

(1) If the hospital cannot determine the MHP of the beneficiary, the hospital shall notify the MHP of the county where the hospital is located, within 24 hours of admission.

(2) The MHP for the county where the hospital is located shall assist the hospital to determine the MHP of the beneficiary. The hospital shall notify the MHP of the beneficiary within 24 hours of determination of the appropriate MHP.

(d) Requests for MHP payment authorization for an emergency admission shall be approved by an MHP when:

(1) A hospital notified the Point of Authorization within 24 hours of admission of a beneficiary to the hospital or within the time required by contract, if applicable.

(2) Written documentation has been provided to the MHP that certifies that a beneficiary met the criteria in (b) at the time of admission.

(3) Written documentation has been provided to the MHP that certifies a beneficiary met the criteria in (b) for the day of admission.

(4) A non-contract hospital includes documentation that the beneficiary could not be safely transferred to a contract hospital or a hospital owned or operated by the MHP of the beneficiary, if the transfer was requested by the MHP.

(5) Any mandatory requirements of the contract negotiated between the hospital and the MHP are met.

(e) After an emergency admission, the MHP of the beneficiary may:

(1) Transfer the beneficiary from a non-contract to a contract hospital or a hospital owned or operated by the MHP of the beneficiary as soon as it is safe to do so. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

(2) Choose to authorize continued stay with a non-contract hospital.

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

1820.230. MHP Payment Authorization by a Utilization Review Committee.

(a) MHP payment authorization for psychiatric inpatient hospital services provided by a Short-Doyle/Medi-Cal hospital, if not made by an MHP's Point of Authorization pursuant to Section 1820.220, shall be made by the hospital's Utilization Review Committee.

(1) The hospital's Utilization Review Committee shall meet the Federal requirements for participants pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

(2) The decision regarding MHP payment authorization shall be documented in writing by the hospital's Utilization Review Committee.

(b) The hospital's Utilization Review Committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission.

(c) At the time of the initial MHP payment authorization, the hospital's Utilization Review Committee or its designee shall specify the date for the subsequent MHP payment authorization determination.

(d) Approval of MHP payment authorization by a hospital's Utilization Review Committee requires that:

(1) When documentation in the clinical record substantiates that the beneficiary met the medical necessity criteria, the hospital's Utilization Review Committee shall authorize payment for each day that services are provided.

(2) Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute treatment facilities per week for placement of the beneficiary subject to the following requirements.

1. The MHP or its designee can waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

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

Subchapter 3. Specialty Mental Health Services Other Than Psychiatric Inpatient Hospital Services.

Article 2. Provision of Services.

1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

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

(D) Elimination Disorders

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

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

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

1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

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

1830.215. MHP Payment Authorization.

(a) Except as provided in Sections 1830.245 and 1830.250, the MHP may require that providers obtain MHP payment authorization of any or all specialty mental health services covered by this subchapter as a condition of reimbursement for the service.

(1) The MHP's authorization function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization function; including any such persons or entities affiliated with a contracting provider to which the MHP has delegated the authorization function.

(2) The individuals who review and approve or deny requests from providers for MHP payment authorization shall be licensed mental health professionals or waivered/registered professionals of the MHP of the beneficiary. Licensed psychiatric technicians and licensed vocational nurses may approve or deny such requests only when the provider indicates that the beneficiary to whom the specialty mental health services will be delivered has an urgent condition.

(b) The MHP may require that providers obtain MHP payment authorization prior to rendering any specialty mental health service covered by this subchapter as a condition of reimbursement for the service, except for those services provided to beneficiaries with emergency psychiatric conditions as provided in Sections 1830.230 and 1830.245.

(c) Notwithstanding the provisions of subsections (a) and (b), the MHP shall require that providers obtain MHP payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services as required in the MHP contract with the Department, and in compliance with Title 42, Code of Federal Regulations (CFR) Part 438, Section 438.210, Subsections (a) and (b), as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Pages 41107 and 41108), which is hereby incorporated by reference.

(d) Whether or not the MHP payment authorization of a specialty mental health service is required pursuant to subsections (a) or (b), the MHP may require that providers notify the MHP of their intent to provide the service prior to the delivery of the service. If the MHP does require such

notice, the MHP shall inform providers of this requirement by including the MHP requirement in a publication commonly available to all providers serving beneficiaries.

NOTE: Authority cited: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code. Reference: Sections 5718, 5767, 5776, 5777, 5778 and 14684, Welfare and Institutions Code; and 42 CFR Part 438, Section 438.210(a) and (b). (Amended to add new subsection (c) effective 7/1/03.)

1830.220. Authorization of Out-of-Plan Services.

(a) "Out-of-Plan Services" means specialty mental health services covered by this subchapter, other than psychiatric nursing facility services, provided to a beneficiary by providers other than the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary.

(b) The MHP shall be required to provide out-of-plan services only under the following circumstances:

(1) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services as described in Section 1820.225 to the extent provided in Section 1830.230.

(2) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric health facility services under the conditions described in Section 1830.245.

(3) When a beneficiary is out of county and develops an urgent condition and there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, especially in terms of timeliness of service.

(4) When there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, the geographic availability of providers, and community standards for availability of providers in the county in which the beneficiary is placed and the beneficiary is placed out of county by:

(A) The Foster Care Program as described in Article 5 (commencing with Section 11400), Chapter 2. Part 3, Division 9 of the Welfare and Institutions Code, the Adoption Assistance Program as described in Chapter 2.1 (commencing with Section 16115), Part 4, Division 9 of the Welfare and Institutions Code, or other foster care arrangement,

(B) A Lanterman-Petris-Short or Probate Conservator or other legal involuntary placement.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 11400, 14684, and 16115, Welfare and Institutions Code.

1830.225. Initial Selection and Change of Person Providing Services.

(a) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide a beneficiary who has been determined by the MHP to meet the medical necessity criteria for outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative or targeted case management services an initial choice of the person who will provide the service to the beneficiary. The MHP may limit the beneficiary's choice, at the election of the MHP, to a choice between two of the individual providers contracting with the MHP or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

(b) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative, or targeted case management services. The MHP may limit the beneficiary's choice of another person to provide services, at the election of the MHP, to an individual provider contracting with the MHP or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777, 14681, 14683, and 14684, Welfare and Institutions Code.

Subchapter 4. Federal Financial Participation.
Article 1. General

1840.112. MHP Claims Certification and Program Integrity.

(a) Each MHP shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

(b) Each MHP shall certify to the Department, in writing, each monthly claim prior to submission to the State for reimbursement. The certification shall attest to the following for each beneficiary with services included in the claim:

(1) An assessment of the beneficiary was conducted in compliance with the requirements established in the MHP contract with the Department.

(2) The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.

(3) The services included in the claim were actually provided to the beneficiary.

(4) Medical necessity was established for the beneficiary as defined under this chapter for the service or services provided, for the timeframe in which the services were provided.

(5) A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department.

(6) For each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the Department.

NOTE: Authority: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code. Reference: Sections 5718, 5719, 5724, 5767, 5776, 5777, 5778 and 14684, Welfare and Institutions Code; and 42 CFR Part 433, Section 433.51, Part 438, Sections 438.604, 438.606 and 438.608, and Part 455, Section 455.18. (Adopted 7-1-03)

Article 3. Specialty Mental Health Services Other than Psychiatric Inpatient Hospital Services.

1840.304. Crosswalk between Service Functions and HCPCS Codes.

(a) When a provider bills the MHP for psychiatrist, psychologist, or EPSDT Supplemental Specialty Mental Health Services using a CPT or other HCPCS code in column A, then the MHP shall claim FFP based on the service function in column B at the units of time listed in column C. The dollar amount claimed shall be in accordance with Section 1840.105.

NOTE: Table deleted. See MHP contract, Exhibit A, Attachment 1, Section __ for current reference.

(b) When a provider that is a hospital outpatient department bills the MHP for facility room use using the HCPCS codes Z7500 or Z7502 in addition to the CPT or other HCPCS code applicable to the specialty mental health service provided to the beneficiary, the MHP shall claim FFP for the combined codes under the applicable CPT or other HCPCS codes listed on the table in subsection (a). When a provider bills the MHP using a CPT or other HCPCS code that is not included on the table in section (a) other than Z7500 or Z7502, the MHP shall determine the appropriate service function for the service provided and shall claim FFP in accordance with Section 1840.308.

(c) An MHP may define a HCPCS code differently than defined in this subchapter in a contract between the MHP and a provider, provided the definition in the contract is not substantially different from the definition in this subchapter. Requiring that a provider other than a

physician use a CPT code to bill for a therapy service shall not be considered to be substantially different.

(d) The lockouts described in Section 1840.215 and Sections 1840.360 through 1840.374 shall apply to claiming of FFP for services claimed under this section. For the purpose of determining lockouts the service shall be considered to be the service identified in column B at the units of time listed in column C.

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

1840.318. Claiming for Service Functions Based on Half Days or Full Days of Time.

(a) Day treatment intensive and day rehabilitation shall be billed as half days or full days of service.

(b) The following requirements apply for claiming of services based on half days or full days of time:

(1) A half day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

(2) A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

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

1840.328. Day Treatment Intensive Services Contact and Site Requirements.

Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site.

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

1840.330. Day Rehabilitation Services Contact and Site Requirements.

Day Rehabilitation Services shall have a clearly established site for services, although all services need not be delivered at that site.

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

1840.350. Day Treatment Intensive Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight beneficiaries or other clients in attendance during the period the program is open.

(1) Physicians

(2) Psychologists or related waivered/registered professionals.

(3) Licensed Clinical Social Workers or related waivered/registered professionals.

(4) Marriage, Family and Child Counselors or related waivered/registered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons who are not solely used to provide Day Treatment Intensive services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

(c) Persons providing services in Day Treatment Intensive programs serving more than 12 clients shall include at least one person from each of two of the following groups:

(1) Physicians

(2) Psychologists or related waivered/registered professionals.

(3) Licensed Clinical Social Workers or related waivered/registered professionals.

(4) Marriage, Family and Child Counselors or related waivered/registered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

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

1840.352. Day Rehabilitation Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Rehabilitation services to ten beneficiaries or other clients in attendance during the period the program is open.

(1) Physicians

(2) Psychologists or related waivered/registered professionals.

(3) Licensed Clinical Social Workers or related waivered/registered professionals.

(4) Marriage, Family and Child Counselors or related waivered/registered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons who are not solely used to provide Day Rehabilitation services may be utilized according to program need, but shall not be included as part of the above ratio formula. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities.

(c) Persons providing services in Day Rehabilitation programs serving more than 12 clients shall include at least two of the following:

(1) Physicians

(2) Psychologists or related waivered/registered professionals.

(3) Licensed Clinical Social Workers or related waivered/registered professionals.

(4) Marriage, Family and Child Counselors or related waivered/registered professionals.

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Mental Health Rehabilitation Specialists as defined in Section 630.

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

Subchapter 5. Problem Resolution Processes

1850.205. Beneficiary Problem Resolution Processes.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a concern or complaint about any specialty mental health service-related issue.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A complaint resolution process.

(2) A grievance process.

(c) For both the complaint resolution process and the grievance process, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the complaint resolution process and the grievance process in the MHP's beneficiary brochure and providing the beneficiary brochure to beneficiaries as described in Section 1810.360.

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

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

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf.

(3) That a beneficiary's legal representative may use the complaint resolution process or the grievance process on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified as having responsibility for assisting a beneficiary with these processes at the beneficiary's request.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a complaint or grievance.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the complaint resolution or grievance process are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for review and, if applicable, implementation of needed system changes.

(d) In addition to meeting the requirements of subsection (c), the complaint resolution process shall, at a minimum:

(1) Provide for resolution of a beneficiary's concerns or complaints as quickly and simply as possible.

(2) Involve simple, informal and easily understood procedures that do not require beneficiaries to present their concerns or complaints in writing.

(3) Inform a beneficiary of his or her right to use the grievance process or request a fair hearing at any time before, during or after the complaint resolution process has begun.

(4) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(e) In addition to meeting the requirements of subsection (c), the grievance process shall, at a minimum:

(1) Require that beneficiaries provide their concerns or complaints to the MHP as a written grievance.

(2) Provide for two levels of review within the MHP.

(3) Provide for a decision on the grievance at each level of review within 30 calendar days of receipt of the grievance by that level of review within the MHP.

(4) Provide for an expedited review of grievances where the beneficiary is grieving a decision by a provider or the MHP to discontinue adult residential or crisis residential services. When the written grievance is received by the MHP prior to the beneficiary's discharge from the services, the beneficiary shall continue to receive the adult residential or crisis stabilization services and the MHP shall continue payment for the services until the MHP responds to the grievance at the first level of review, at which point action may be taken by the provider or the MHP as appropriate based on the grievance decision. Services shall not be continued if the provider or the MHP determines that ongoing placement of the beneficiary in that facility poses a danger to the beneficiary or others.

(5) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(6) Provide for:

(A) Recording the grievance in a grievance log within one working day of the date of receipt of the grievance. The log entry shall include but not be limited to:

1. The name of the beneficiary.

2. The date of receipt of the grievance.

3. The nature of the problem.

(B) Recording the final disposition of a grievance, including the date the decision is sent to the beneficiary, or documenting the reason(s) that there has not been final disposition of the grievance.

(C) An MHP staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance.

(D) Notifying the beneficiary or the appropriate representative in writing of the grievance decision and documenting the notification or efforts to notify the beneficiary, if he or she could not be contacted. When the notice contains the decision of the MHP's first level of review, the notice shall include the beneficiary's right to appeal to the second level of review and to request a fair hearing if the beneficiary disagrees with the decision instead of, before, during or after filing the grievance at the second level of review. When the notice contains the decision of the MHP's second level of review, the notice shall include the beneficiary's right to request a fair hearing if the beneficiary disagrees with the decision.

(E) If any providers were cited by the beneficiary or otherwise involved in the grievance, notifying those providers of the final disposition of the beneficiary's grievance.

(f) An MHP's grievance log and any other grievance process files, and any complaint resolution process files shall be open to review by the department, the State Department of Health Services, and any appropriate oversight agency.

(g) Nothing in this section precludes a provider other than the MHP from establishing complaint or grievance processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

(1) The MHP delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation.

(2) The provider's beneficiary problem resolution process fully complies with this section.

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

(h) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code.
Reference: Sections 5520 and 14684, Welfare and Institutions Code.

1850.210. Fair Hearing and Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP acts to deny an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with this subsection. Notice in response to a request for continuation of a specialty mental health service shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action under this subsection shall not be required in the following situations:

(1) The denial is a denial of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.

(2) The denial is a non-binding verbal description to a provider of the specialty mental health services which may be approved by the MHP.

(b) The MHP of the beneficiary shall provide the beneficiary with a Notice of Action when the MHP defers action on an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. The Notice of Action shall be delayed for 30 calendar days to allow the provider of the specialty mental health service time to submit the additional

information requested by the MHP and to allow time for the MHP to make a decision. If, after 30 calendar days from the MHP's receipt of the MHP payment authorization request, the provider has not complied with the MHP's request for additional information, the MHP shall provide the beneficiary a notice of action to deny the service pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the MHP shall take appropriate action on the MHP payment authorization request as supplemented by the additional information, including providing a Notice of Action to the beneficiary if the service is denied or modified or if the MHP defers action on the MHP payment authorization request for an additional period of time. The Notice of Action under this subsection shall not be required when the MHP defers action on an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(c) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary. Notice in response to an initial request from a provider shall be provided in accordance with Title 22, Section 51014.1. The Notice of Action pursuant to this subsection shall not be required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services. The Notice of Action under this subsection shall not be required when the MHP modifies an MHP payment authorization request for a specialty mental health service that has already been provided to the beneficiary.

(d) The written Notice of Action issued pursuant to subsections (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the MHP.

(2) The reason for the action taken.

(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.

(4) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.

(D) The time limits for requesting fair hearing.

(e) The fair hearings under this section shall be administered by the State Department of Health Services.

(f) For the purpose of this section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.1, shall mean the MHP.

(g) For the purposes of this section, "medical service" as cited in Title 22, Section 51014.1, shall mean those specialty mental health services that are subject to prior authorization by an MHP pursuant to subchapters 2 and 3.

(h) The provisions of this section do not apply to the decisions of providers including the MHP serving beneficiaries when prior authorization of the service by the MHP's authorization procedures is not a condition of payment to the provider for the specialty mental health service.

(i) When a Notice of Action would not be required under subsections (a), (b), or (c), the MHP of the beneficiary shall provide a beneficiary with Notice of Action under this subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The Notice of Action under this subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with subsection (d) and shall specify:

(1) The reason the medical necessity criteria was not met.

(2) The beneficiary's options for obtaining care outside the MHP, if applicable.

(3) The beneficiary's right to request a second opinion on the determination.

(4) The beneficiary's right to file a complaint or grievance with the MHP.

(5) The beneficiary's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limits for requesting fair hearing.

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

1850.215. Medical Assistance for Beneficiary Pending Fair Hearing Decision.

A beneficiary receiving specialty mental health services pursuant to this chapter shall have a right to file for continuation of specialty mental health services pending fair hearing pursuant to Title 22, Section 51014.2. For the purpose of this section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.2, shall mean the MHP. The time limits for filing for a continuation of services pursuant to Title 22, Section 51014.2 shall not be extended by a beneficiary's decision to pursue an MHP's beneficiary problem resolution process as described in Section 1850.205.

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

1850.305 Provider Problem Resolution and Appeal Processes.

(a) An MHP shall develop provider problem resolution and appeal processes that enable providers to resolve MHP payment authorization issues or other complaints and concerns.

(b) The MHP shall ensure that participating providers are provided written information regarding the provider problem resolution and appeal processes.

(c) The Provider Problem Resolution Process shall include, at a minimum:

(1) A means to identify and resolve provider concerns and problems quickly and easily.

(2) Utilize simple, informal, and easily understood procedures.

(3) Inform providers of their right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP.

(d) The Provider Appeal Process shall include the following:

(1) A provider may appeal a denied or modified request for MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to the MHP within 90 calendar days of the date of receipt of

the non-approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the time frames required by Sections 1820.220 or 1830.250, or established by the MHP pursuant to Section 1830.215.

(2) The MHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

(A) If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

(B) If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the department pursuant to subsection (e).

(C) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

(D) If applicable, the MHP shall have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the TAR to the fiscal intermediary for processing.

(3) If an MHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied by the MHP. If applicable under subsection (e), the provider may appeal directly to the department.

(e) When an appeal concerning the denial or modification of an MHP payment authorization request for the specialty mental health services provided in an emergency as described in Sections 1820.225, 1830.230, and 1830.245 is denied in full or in part by the MHP's Provider Appeal Process on the basis that the provider did not comply with the required timelines for notification or submission of the MHP payment request or that the medical necessity criteria were not met, the provider may appeal the denial or modification to the department.

(1) Hospitals and the individual, group or organizational providers who have provided specialty mental health services under Sections 1820.225, 1830.230, and 1830.245 to a beneficiary during the psychiatric inpatient hospital stay that is the subject of the appeal may appeal separately to the department unless they have agreed to another arrangement as a term of their contract with the MHP.

(2) If a provider chooses to appeal to the department an MHP's denial of MHP payment authorization, the appeal shall be submitted in writing, along with supporting documentation, within 30 calendar days from the date of the MHP's written decision of denial. The provider may appeal

to the department within 30 calendar days after 60 calendar days from submission to the MHP, if the MHP fails to respond. Supporting documentation shall include, but not be limited to:

(A) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

(B) Clinical records supporting the existence of medical necessity if at issue.

(C) A summary of reasons why the MHP should have approved the MHP payment authorization.

(D) A contact person(s) name, address and phone number.

(3) The department shall notify the MHP and the provider of its receipt of a request for appeal pursuant to subsection (d) within seven calendar days. The notice to the MHP shall include a request to the MHP for specific documentation supporting denial of the MHP payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal pursuant to subsection (d)(1).

(4) The MHP shall submit the requested documentation within 21 calendar days or the department shall decide the appeal based solely on the documentation filed by the provider.

(5) The department shall have 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation, whichever is earlier, to notify the provider and the MHP, in writing, of its decision, including a statement of the reasons for the decision that addresses each issue raised by the provider and the MHP, and any actions required by the MHP or the provider to implement the decision. At the election of the provider, if the department fails to act within the 60 calendar days, the appeal may be considered to have been denied by the department.

(A) The department may allow both a provider representative(s) and the MHP representative(s) an opportunity to present oral argument to the department.

(B) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the department's decision to uphold the appeal.

(C) If applicable, the MHP shall have 14 calendar days from the receipt of the provider's revised MHP payment authorization request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

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

1850.405. Resolution of Disputes between MHPs regarding MHP of Beneficiary.

(a) Under the following arbitration processes the MHP of the beneficiary may be determined to be different than that specified in the Medi-Cal Eligibility Data System (MEDS) file.

(b) Any two or more MHPs may develop an arbitration agreement to provide for determining final responsibility for MHP payment authorization as described in subchapters 2 and 3 when there is a dispute between the participating MHPs. Each arbitration agreement must:

(1) Provide for the selection of an arbitrator.

(2) Include timelines for filing and resolution.

(3) Include criteria that will serve as a basis for a decision.

(4) Specify that decisions reached under the arbitration process will be final.

(5) Be signed by all participating MHPs or their designees.

(6) Require that all decisions of the arbitrator shall be in writing.

(7) Provide that a copy of each decision shall be forwarded to the affected MHPs within 14 calendar days of the decision.

(c) In cases where there is a disagreement between MHPs that are not participating in an arbitration process, the arbitration process shall be as follows:

(1) Each MHP shall provide the department with at least one individual available to serve as an arbitrator. The MHP shall confirm or update the available individuals annually. The department shall provide a listing of the available individuals to the MHPs annually by October 1. The parties to the dispute may agree to a single arbitrator. If the parties to the dispute cannot agree on a single arbitrator, the parties shall each select an arbitrator from the list of available individuals, except that an individual identified by either involved MHP may not be selected. The selected arbitrators shall select a third arbitrator who is not an individual identified by either involved MHP from the listing.

(2) The arbitrators' services shall be reimbursed at the hourly rate charge by the State Office of Administrative Hearings for hearings it conducts for other state agencies, not to exceed a total of ten hours. The parties shall share equally in paying for the arbitrators' services. Payment shall be made directly to the arbitrators unless the arbitrator is an employee of the MHP, in which case payment shall be made to that MHP.

(3) The arbitrators' decision as to the MHP of the beneficiary shall be based on a review of the facts in relation to the following criteria:

(A) If a beneficiary has moved to a county or acts to establish residency in a county and has a clear intent to reside in the county, the MHP for that county shall be considered the MHP of the beneficiary.

(B) If a beneficiary is a Lanterman-Petris-Short or Probate Conservatee, the MHP for the county in which the beneficiary is conserved shall be considered the MHP of the beneficiary.

(C) If a beneficiary has been placed in legal custody by a county, the MHP for the county that initiated the legal proceeding shall be considered the MHP of the beneficiary. If a beneficiary is on parole or in a conditional release program and is restricted to a particular area, the MHP for the county which includes the area to which the beneficiary is restricted shall be the MHP of the beneficiary.

(D) If a beneficiary has adopted a transient, nomadic lifestyle and has a clear intent to continue this lifestyle, the MHP for the county in which the beneficiary presents for services shall be considered the MHP of the beneficiary.

(E) If a beneficiary, because of the beneficiary's mental status, is unable to form or express a clear intent to reside anywhere, the following may be considered evidence that the MHP for the county involved would be the MHP of the beneficiary:

1. The county that originated residential, medical, or psychiatric placement.

2. The county in which the beneficiary has current housing.

3. The county that has paid general assistance to the beneficiary.

4. The county in which the beneficiary has received ongoing community mental health clinical care during the last six months.

(F) Where the facts do not clearly meet the criteria, the arbitrators' decision shall be reasonable in light of the facts presented using the criteria in (A) through (E) as a general guidelines.

(4) The affected MHPs shall provide relevant documentation to arbitrators no later than 21 calendar days after the arbitrators have been selected.

(5) The arbitrators shall decide on the issue no later 60 calendar days

(A) from the date documentation is received from the affected MHPs, or

(B) from 21 calendar days after the arbitrator has been selected, whichever is sooner.

(6) The arbitrators shall issue the decision in writing to the affected MHPs within 14 calendar days of the decision.

(d) When the arbitrators acting under either subsections (b) or (c) determine that an MHP is responsible for payment for specialty mental health services previously authorized by another MHP, the MHP found responsible for payment of services shall perform, within 14 calendar days from the date of the arbitrator's decision, any action required of the MHP to implement the decision of the arbitration process. The department reserves the right to take action necessary to implement the decision of the arbitration process if the MHP found to be responsible fails to comply with the decision.

(e) A dispute regarding the MHP of the beneficiary shall not delay medically necessary services to beneficiaries. The MHP of the beneficiary as identified on the MEDS file shall be responsible for providing or authorizing and paying for the service until the dispute is resolved.

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

FEDERAL REGULATONS CROSS-REFERENCED IN CONTRACT

Various Parts related to PART 438—MANAGED CARE

Sec. 422.128 Information on Advance Directives

(a) Each M+C organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, advance directive has the meaning given the term in Sec. 489.100 of this chapter.
(b) An M+C organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the M+C organization.
(1) An M+C organization must provide written information to those individuals with respect to the following:
(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.
(ii) The M+C organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the M+C organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:
(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.
(B) Identify the state legal authority permitting such objection.
(C) Describe the range of medical conditions or procedures affected by the conscience objection.
(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the M+C organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The M+C organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.
(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.
(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.
(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.
(H) Provide for education of staff concerning its policies and procedures on advance directives.

(I) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the M+C organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An M+C organization must be able to document its community education efforts.
(2) The M+C organization--
(i) Is not required to provide care that conflicts with an advance directive; and
(ii) Is not required to implement an advance directive if, as a matter of conscience, the M+C organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.
(3) The M+C organization must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

Sec. 489.100 Definition.

For purposes of this part, advance directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Sec. 431.244 Hearing decisions.

. . . .
(f) The agency must take final administrative action as follows:
(1) Ordinarily, within 90 days from the earlier of the following:
(i) The date the enrollee filed an MCO or PIHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing; or
(ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing.
(2) As expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP, the case file and information for any appeal of a denial of a service that, as indicated by the MCO or PIHP—
(i) Meets the criteria for expedited resolution as set forth in Sec. 438.410(a) of this chapter, but was not resolved within the timeframe for expedited resolution; or
(ii) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the enrollee.
(3) If the State agency permits direct access to a State fair hearing, as expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, directly from an MCO or PIHP enrollee, a fair hearing request on a decision to deny a service that it determines meets the criteria for expedited resolution, as set forth in Sec. 438.410(a) of this chapter. . . .

PART 438—MANAGED CARE
Subpart A—General Provisions

Sec. 438.6 Contract requirements.

(a) Regional office review. The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in Sec. 438.806.
(b) Entities eligible for comprehensive risk contracts. (N/A)
(c) Payments under risk contracts. (N/A)
(d) Enrollment discrimination prohibited. (N/A)
(f) Compliance with contracting rules. All contracts under this subpart must:
(1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; and
(2) Meet all the requirements of this section.
(g) Inspection and audit of financial records. Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors.
(h) Physician incentive plans.
(1) MCO, PIHP, and PAHP contracts must provide for compliance with the requirements set forth in Secs. 422.208 and 422.210 of this chapter.
(2) In applying the provisions of Secs. 422.208 and 422.210 of this chapter, references to ``M+C organization", ``CMS", and ``Medicare beneficiaries" must be read as references to ``MCO, PIHP, or PAHP", ``State agency" and ``Medicaid recipients", respectively.
(i) Advance directives.
(1) All MCO and PIHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives.
(2) All PAHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in Sec. 489.102(a) of this chapter.
(3) The MCO, PIHP, or PAHP subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.
(4) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.
(j) Special rules for certain HIOs. (N/A)
(k) Additional rules for contracts with PCCMs. (N/A)
(l) Subcontracts. All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.
(m) Choice of health professional. The contract must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

Sec. 438.10 Information requirements.
(a) Terminology. As used in this section, the following terms have the indicated meanings:
Enrollee means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.
Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.
(b) Basic rules.

(1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
(2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.
(3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.
(c) Language. The State must do the following:
(1) Establish a methodology for identifying the prevalent non- English languages spoken by enrollees and potential enrollees throughout the State. ``Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.
(2) Make available written information in each prevalent non- English language.
(3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.
(4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.
(5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—
(i) That oral interpretation is available for any language and written information is available in prevalent languages; and
(ii) How to access those services.
(d) Format. (1) Written material must—
(i) Use easily understood language and format; and
(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
(2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
(e) Information for potential enrollees.
(1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:
(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.
(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHPs, or PCCMs.
(2) The information for potential enrollees must include the following:
(i) General information about—
(A) The basic features of managed care;
(B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and
(C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;
(ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request:
(A) Benefits covered.
(B) Cost sharing, if any.
(C) Service area.

(D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.
(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service.
(f) General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs. Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:
(1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.
(2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.
(3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment.
(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as ``significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.
(5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.
(6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees:
(i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.
(ii) Any restrictions on the enrollee's freedom of choice among network providers.
(iii) Enrollee rights and protections, as specified in Sec. 438.100.
(iv) Information on grievance and fair hearing procedures, and for MCO and PIHP enrollees, the information specified in Sec. 438.10(g)(1), and for PAHP enrollees, the information specified in Sec. 438.10(h).
(v) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
(vi) Procedures for obtaining benefits, including authorization requirements.
(vii) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.
(viii) The extent to which, and how, after-hours and emergency coverage are provided, including:
(A) What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in Sec. 438.114(a).

(B) The fact that prior authorization is not required for emergency services.
(C) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
(D) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract.
(E) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.
(ix) The poststabilization care services rules set forth at Sec. 422.113(c) of this chapter.
(x) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
(xi) Cost sharing, if any.
(xii) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP, or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.
(g) Specific information requirements for enrollees of MCOs and PIHPs. In addition to the requirements in Sec. 438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees:
(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in Secs. 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:
(i) For State fair hearing—
(A) The right to hearing;
(B) The method for obtaining a hearing; and
(C) The rules that govern representation at the hearing.
(ii) The right to file grievances and appeals.
(iii) The requirements and timeframes for filing a grievance or appeal.
(iv) The availability of assistance in the filing process.
(v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
(vi) The fact that, when requested by the enrollee—
(A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and
(B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
(vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
(2) Advance directives, as set forth in Sec. 438.6(i)(2).
(3) Additional information that is available upon request, including the following:
(i) Information on the structure and operation of the MCO or PIHP.
(ii) Physician incentive plans as set forth in Sec. 438.6(h) of this chapter.
(h) Specific information for PAHPs. . . ..
(i) Special rules: States with mandatory enrollment under State plan authority—. . . .

Subpart C--Enrollee Rights and Protections

Sec. 438.100 Enrollee rights.
(a) General rule. The State must ensure that—

(1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and
(2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.
(b) Specific rights—
(1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.
(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to –
(i) Receive information in accordance with Sec. 438.10.
(ii) Be treated with respect and with due consideration for his or her dignity and privacy.
(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in Sec. 438.10(f)(6)(xiii).)
(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.
(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Sec. 164.524 and 164.526.
(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with Secs. 438.206 through 438.210.
(c) Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.
(d) Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

Subpart D--Quality Assessment and Performance Improvement

Sec. 438.204 Elements of State quality strategies.
At a minimum, State strategies must include the following:
(a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.
(b) Procedures that—
(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
(2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
(3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.
(d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
(e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
(f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

Sec. 438.240 Quality assessment and performance improvement program.
(a) General rules.
(1) The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.
(2) CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.
(b) Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:
(1) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
(2) Submit performance measurement data as described in paragraph (c) of this section.
(3) Have in effect mechanisms to detect both underutilization and overutilization of services.
(4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
(c) Performance measurement. Annually each MCO and PIHP must—
(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of Sec. 438.204(c) and Sec. 438.240(a)(2);
(2) Submit to the State, data specified by the State, that enables the State to measure the MCO's or PIHP's performance; or
(3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.
(d) Performance improvement projects.
(1) MCOs and PIHPs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following:
(i) Measurement of performance using objective quality indicators.
(ii) Implementation of system interventions to achieve improvement in quality.
(iii) Evaluation of the effectiveness of the interventions.
(iv) Planning and initiation of activities for increasing or sustaining improvement.
(2) Each MCO and PIHP must report the status and results of each project to the State as requested, including those that incorporate the requirements of Sec. 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to

generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
(e) Program review by the State.
(1) The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program. The review must include—
(i) The MCO's and PIHP's performance on the standard measures on which it is required to report; and
(ii) The results of each MCO's and PIHP's performance improvement projects.
(2) The State may require that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

Subpart F--Grievance System
(Please note that not all provisions apply to Mental Health Plans per approved waiver renewal request. See contract terms to identify specific requirements of the MHPs.)

Sec. 438.400 Statutory basis and definitions.
(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.
(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
(b) Definitions. As used in this subpart, the following terms have the indicated meanings:
Action means-- In the case of an MCO or PIHP—
(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure to provide services in a timely manner, as defined by the State;
(5) The failure of an MCO or PIHP to act within the timeframes provided in Sec. 438.408(b); or
(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under Sec. 438.52(b)(2)(ii), to obtain services outside the network.
Appeal means a request for review of an action, as "action" is defined in this section.
Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Sec. 438.402 General requirements.
(a) The grievance system. Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.
(b) Filing requirements—
(1) Authority to file.—

(i) An enrollee may file a grievance and an MCO or PIHP level appeal, and may request a State fair hearing.
(ii) A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.
(2) Timing. The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the MCO's or PIHP's notice of action. Within that timeframe—
(i) The enrollee or the provider may file an appeal; and
(ii) In a State that does not require exhaustion of MCO and PIHP level appeals, the enrollee may request a State fair hearing.
(3) Procedures.
(i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO or the PIHP.
(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

Sec. 438.404 Notice of action.
(a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding.
(b) Content of notice. The notice must explain the following:
(1) The action the MCO or PIHP or its contractor has taken or intends to take.
(2) The reasons for the action.
(3) The enrollee's or the provider's right to file an MCO or PIHP appeal.
(4) If the State does not require the enrollee to exhaust the MCO or PIHP level appeal procedures, the enrollee's right to request a State fair hearing.
(5) The procedures for exercising the rights specified in this paragraph.
(6) The circumstances under which expedited resolution is available and how to request it.
(7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
(c) Timing of notice. The MCO or PIHP must mail the notice within the following timeframes:
(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in Secs. 431.211, 431.213, and 431.214 of this chapter.
(2) For denial of payment, at the time of any action affecting the claim.
(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in Sec. 438.210(d)(1).
(4) If the MCO or PIHP extends the timeframe in accordance with Sec. 438.210(d)(1), it must—
(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
(5) For service authorization decisions not reached within the timeframes specified in Sec. 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
(6) For expedited service authorization decisions, within the timeframes specified in Sec. 438.210(d).

Sec. 438.406 Handling of grievances and appeals.
(a) General requirements. In handling grievances and appeals, each MCO and each PIHP must meet the following requirements:
(1) Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
(2) Acknowledge receipt of each grievance and appeal.
(3) Ensure that the individuals who make decisions on grievances and appeals are individuals—
(i) Who were not involved in any previous level of review or decision-making; and
(ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
(A) An appeal of a denial that is based on lack of medical necessity.
(B) A grievance regarding denial of expedited resolution of an appeal.
(C) A grievance or appeal that involves clinical issues.
(b) Special requirements for appeals. The process for appeals must:
(1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
(2) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO or PIHP must inform the enrollee of the limited time available for this in the case of expedited resolution.)
(3) Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
(4) Include, as parties to the appeal—
(i) The enrollee and his or her representative; or
(ii) The legal representative of a deceased enrollee's estate.

Sec. 438.408 Resolution and notification: Grievances and appeals.
(a) Basic rule. The MCO or PIHP must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.
(b) Specific timeframes.—
(1) Standard disposition of grievances. For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day the MCO or PIHP receives the grievance.
(2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.
(3) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the MCO or PIHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.
(c) Extension of timeframes.—
(1) The MCO or PIHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—
(i) The enrollee requests the extension; or
(ii) The MCO or PIHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) Requirements following extension. If the MCO or PIHP extends the timeframes, it must--for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.
(d) Format of notice.—
(1) Grievances. The State must establish the method MCOs and PIHPs will use to notify an enrollee of the disposition of a grievance.
(2) Appeals.
(i) For all appeals, the MCO or PIHP must provide written notice of disposition.
(ii) For notice of an expedited resolution, the MCO or PIHP must also make reasonable efforts to provide oral notice.
(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:
(1) The results of the resolution process and the date it was completed.
(2) For appeals not resolved wholly in favor of the enrollees—
(i) The right to request a State fair hearing, and how to do so;
(ii) The right to request to receive benefits while the hearing is pending, and how to make the request; and
(iii) That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.
(f) Requirements for State fair hearings.—
(1) Availability. The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than 20 or in excess of 90 days from whichever of the following dates applies—
(i) If the State requires exhaustion of the MCO or PIHP level appeal procedures, from the date of the MCO's or PIHP's notice of resolution; or
(ii) If the State does not require exhaustion of the MCO or PIHP level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on the MCO's or PIHP's notice of action.
(2) Parties. The parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Sec. 438.410 Expedited resolution of appeals.
(a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function..
(b) Punitive action. The MCO or PIHP must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.
(c) Action following denial of a request for expedited resolution. If the MCO or PIHP denies a request for expedited resolution of an appeal, it must—
(1) Transfer the appeal to the timeframe for standard resolution in accordance with Sec. 438.408(b)(2);
(2) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

Sec. 438.414 Information about the grievance system to providers and subcontractors.
The MCO or PIHP must provide the information specified at Sec. 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

Sec. 438.416 Recordkeeping and reporting requirements.
The State must require MCOs and PIHPs to maintain records of grievances and appeals and must review the information as part of the State quality strategy.

Sec. 438.420 Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.
(a) Terminology. As used in this section, "*timely" filing* means filing on or before the later of the following:
(1) Within ten days of the MCO or PIHP mailing the notice of action.
(2) The intended effective date of the MCO's or PIHP's proposed action.
(b) Continuation of benefits. The MCO or PIHP must continue the enrollee's benefits if—
(1) The enrollee or the provider files the appeal timely;
(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
(3) The services were ordered by an authorized provider;
(4) The original period covered by the original authorization has not expired; and
(5) The enrollee requests extension of benefits.
(c) Duration of continued or reinstated benefits. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
(1) The enrollee withdraws the appeal.
(2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
(3) A State fair hearing Office issues a hearing decision adverse to the enrollee.
(4) The time period or service limits of a previously authorized service has been met.
(d) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in Sec. 431.230(b) of this chapter.

Sec. 438.424 Effectuation of reversed appeal resolutions.
(a) Services not furnished while the appeal is pending. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO or PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
(b) Services furnished while the appeal is pending. If the MCO or PIHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the PIHP or the State must pay for those services, in accordance with State policy and regulations.

Subpart H--Certifications and Program Integrity

Sec. 438.604 Data that must be certified.
(a) Data certifications. When State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP, the State must require certification of the data as provided in Sec. 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the State and contained in contracts, proposals, and related documents.

(b) Additional certifications. Certification is required, as provided in Sec. 438.606, for all documents specified by the State.

Sec. 438.606 Source, content, and timing of certification.
(a) Source of certification. For the data specified in Sec. 438.604, the data the MCO or PIHP submits to the State must be certified by one of the following:
(1) The MCO's or PIHP's Chief Executive Officer.
(2) The MCO's or PIHP's Chief Financial Officer.
(3) An individual who has delegated authority to sign for, and who reports directly to, the MCO's or PIHP's Chief Executive Officer or Chief Financial Officer.
(b) Content of certification. The certification must attest, based on best knowledge, information, and belief, as follows:
(1) To the accuracy, completeness and truthfulness of the data.
(2) To the accuracy, completeness and truthfulness of the documents specified by the State.
(c) Timing of certification. The MCO or PIHP must submit the certification concurrently with the certified data.

Sec. 438.610 Prohibited Affiliations with Individuals Debarred by Federal Agencies.
(a) General requirement. An MCO, PCCM, PIHP, or PAHP may not knowingly have a relationship of the type described in paragraph (b) of this section with the following:
(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.
(b) Specific requirements. The relationships described in this paragraph are as follow:
(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP.
(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity.
(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.
(c) Effect of Noncompliance. If a State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance with paragraphs (a) and (b) of this section, the State:
(1) Must notify the Secretary of the noncompliance.
(2) May continue an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary directs otherwise.
(3) May not renew or otherwise extend the duration of an existing agreement with the MCO, PCCM, PIHP, or PAHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.
(d) Consultation with the Inspector General. Any action by the Secretary described in paragraphs (c)(2) or (c)(3) of this section is taken in consultation with the Inspector General.