COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

BOARD OF SUPERVISORS

GLORIA MOLINA
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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

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

October 16, 2012

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

8 October 16, 2012

SACHI A. HAMAI
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 OF RETROACTIVE MENTAL HEALTH PLAN AGREEMENT WITH THE STATE DEPARTMENTS OF MENTAL HEALTH AND HEALTH CARE SERVICES FOR MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES FOR THE PERIOD FROM APRIL 1, 2012, TO DECEMBER 31, 2012 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request adoption of a resolution retroactively approving the Mental Health Plan Agreement for the term of April 1, 2012, through December 31, 2012, with the California State Departments of Mental Health and Health Care Services for the provision of specialty mental health services to Medi-Cal beneficiaries of Los Angeles County.

IT IS RECOMMENDED THAT THE BOARD:

1. Adopt and instruct the Chairman to sign and execute the attached resolution (Attachment I) retroactively approving the Mental Health Plan (MHP) Agreement (Agreement No. 11-73020-000) (Agreement) for the provision of continued specialty mental health services to Medi-Cal beneficiaries of Los Angeles County (County) and for the receipt of federal revenue in the amount of $998,783,583, for the period from April 1, 2012, through no later than December 31, 2012. This Agreement is a tri-party agreement between the County and the California State (State) Department of Mental Health (SDMH) and Department of Health Care Services (DHCS).

2. Authorize the Director of Mental Health (Director), or his designee, to sign three copies of the Agreement (Attachment II) and forward them to the State.

3. Delegate authority to the Director, or his designee, to sign subsequent amendments or modifications to the Agreement that may be required by the State, upon prior County Counsel approval. The Director will notify your Board and the Chief Executive Officer (CEO) of such Agreement changes in writing ten days prior to execution of each amendment.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The recommended actions are required for the County to continue to operate as the MHP and administer specialty mental health services, also known as medically necessary Covered Mental Health Services, to Medi-Cal beneficiaries of Los Angeles County and to receive federal reimbursement for these services. The MHP Agreement sets forth the terms and reporting requirements to continue operations and funding of the MHP. Medically necessary Covered Mental Health Services to beneficiaries include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, psychiatric health facility services, and targeted case management as defined in Title 9 of the California Code of Regulations, and in California's Medicaid State Plan. Covered mental health services also include psychiatric inpatient hospital services and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services as defined in Title 9.

Due to the passage of Assembly Bill (AB) 102, effective July 1, 2012, the SDMH's functions have been transferred to DHCS. As such, this Agreement is established by SDMH but will be transferred to DHCS. Therefore, this Agreement is being issued as a tri-party agreement by the State in an effort to facilitate a smooth transition, and it is only effective until DHCS and the County execute a successor MHP Agreement or December 31, 2012, whichever is earlier.

This Agreement was received by the County from SDMH on July 24, 2012, which resulted in this request for your Board's retroactive approval.

Implementation of Strategic Plan Goals

The recommended actions support the County's Strategic Plan Goal 2, Fiscal Sustainability and Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

The MHP Agreement includes federal revenue in the amount of $998,783,583 for the period of April 1, 2012, through December 31, 2012. The amount of the MHP Agreement is based on the estimated statewide percentage for the County of Los Angeles for the following:

- Children and adult services
- Administrative, Quality Assurance and Utilization Review
- Cost settlements and Audits
- Supplemental Claims and AB 1297 payments above the State Maximum Allowance

The approval of the MHP Agreement will allow federal reimbursement by the State for mental health services provided to Medi-Cal eligible beneficiaries and other related activities as stated above, for the period of April 1, 2012, through December 31, 2012. DMH estimates that approximately $771

million, out of the Agreement amount of $998,783,583, will be reimbursed by the State based on actual services provided, cost settlements, and audits for the term of the Agreement.

There is no impact on net County cost if this Agreement is approved. Failure to have a signed Agreement in place will result in non-reimbursement of federal revenue to the County and Tri-City Mental Health Center (Tri-City) for services that have been and will be rendered for Medi-Cal eligible beneficiaries and other related activities.

As of July 1, 2012, the State suspended reimbursement to Department of Mental Health (DMH) for said services until the MHP Agreement is signed and executed. The suspension of reimbursement is estimated to impact the cash flow to the General Fund by $150 million until the MHP Agreement is signed and payments are received from the State which is expected to occur by end of November 2012.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

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 SDMH to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this State, and by this MHP Agreement, DMH agrees to operate the MHP for Los Angeles County.

W&I Code, Sections 5775-5783 establish managed mental health care plans for the counties of the State, administered by SDMH. However, in accordance with the realignment of State Agency responsibility directed in AB 102, this function and many others currently performed by SDMH have been transferred to the DHCS effective July 1, 2012.

Consequently, the Agreement before your Board is an agreement by the County with SDMH and DHCS. DMH anticipates returning to your Board with an Agreement with DHCS for the period beginning January 1, 2013, once it is received.

The Agreement has been reviewed and approved as to form by County Counsel.

CONTRACTING PROCESS

State regulations require a contractual agreement between SDMH and the County to continue funding the MHP 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 W&I Code.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

This Agreement will provide the County with continued funding to administer specialty mental health services provided to the County's Medi-Cal beneficiaries. Failure to have a signed Agreement in place will result in non-reimbursement of federal revenue to the County and Tri-City for services that have been and will be rendered for Medi-Cal eligible beneficiaries and other related activities. While Tri-City receives its Realignment funds directly from the State via a special agreement with the State,

it relies on DMH to sign the MHP Agreement so DMH can direct Tri-City's share of the federal revenue to Tri-City.

CONCLUSION

DMH will need the original executed resolution. It is requested that the Executive Officer of the Board notify DMH Contracts Development and Administration Division at (213) 738-4684 when the document is available.

Respectfully submitted,

MARVIN J. SOUTHARD, D.S.W.
Director of Mental Health

MJS:RS:PW:RK:mi

Enclosures

c: Chief Executive Officer
County Counsel
Auditor-Controller
Executive Officer, Board of Supervisors
Chairperson, Mental Health Commission

ATTACHMENT I

RESOLUTION OF THE BOARD OF SUPERVISORS OF COUNTY OF LOS ANGELES STATE OF CALIFORNIA

Now, Therefore, Be It Resolved that the Board of Supervisors of the County of Los Angeles, does hereby authorize Marvin J. Southard, D.S.W., Director of Mental Health, to sign the State Mental Health Plan Agreement No. 11-73020-000 with the State of California Department of Mental Health for the period April 1, 2012, through December 31, 2012. It is further resolved that the Board approves and authorizes the Director of the Department of Mental Health to approve future Amendments or Modifications of Agreement No. 11-73020-000.

The foregoing Resolution was adopted on the 16th day of October, 2012, by the Board of Supervisors of the County of Los Angeles, and ex-officio the governing body of all other special assessment and taxing districts, agencies and authorities, for which said Board so acts.

Chairman, Board of Supervisors

Attest:

SACHI HAMAI, Executive Officer
Board of Supervisors of the
County of Los Angeles

By _____
Deputy

APPROVED AS TO FORM:

JOHN F. KRATTLI
COUNTY COUNSEL

By _____
Deputy County Counsel

MI:U:\Blue folder\Murali\\State MHP Contract\Attachment I Resolution

HOA.916780.1

STATE OF CALIFORNIA

STANDARD AGREEMENT

STD 213 (Rev 06/03)

ATTACHMENT II

AGREEMENT NUMBER	
11-73020-000	
REGISTRATION NUMBER	

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

STATE AGENCY'S NAME

California Department of Mental Health AND California Department of Health Care Services

CONTRACTOR'S NAME

Los Angeles County Mental Health

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

3. The maximum amount of this Agreement is: $ 998,783,583

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

Exhibit A – Scope of Work	Pages 3-7
Exhibit A1 – Service Delivery, Administrative and Operational Requirements	Pages 9-67
Exhibit B - Payment Provisions	Pages 68-74
Exhibit C* – General Terms and Conditions	GTC-610
Exhibit D – Special Provisions	Pages 76-80
Exhibit E – Additional Provisions	Pages 82-85
Exhibit F – HIPAA Business Associate Addendum	Pages 86-101
Attachment A – Business Associate Data Security Requirements	Pages 102-106

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

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

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
Los Angeles County Mental Health

BY *(Authorized Signature)* | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Marvin J. Southard,, DSW, Mental Health Director

ADDRESS
550 S. Vermont Avenue
Los Angeles, CA 90020

STATE OF CALIFORNIA

AGENCY NAME
See Page 2 for Official Signatures

BY *(Authorized Signature)* | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

ADDRESS

California Department of General Services Use Only

☐ Exempt per:

DMH USE ONLY

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

California Department of Mental Health – Contract Number 11-73020-000

_____

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

California Department of Health Care Services

_____

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

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

TABLE OF CONTENTS

EXHIBIT A

1. Term of Contract.

April 1, 2012 – December 31, 2012

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

2. Scope of Work.

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

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

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

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

Department

County Technical Assistance:

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

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

Contractor

Los Angeles County Mental Health
Marvin J. Southard,, DSW, Mental Health Director
Phone: 213-738-4601
Fax: 213-386-1297

Direct all inquiries to:

Department

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

Contractor

Los Angeles County Mental Health
Marvin J. Southard,, DSW, Mental Health Director
550 S. Vermont Avenue
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.

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

3. General Authority.

This contract is entered into in accordance with the provisions of Part 2.5 (commencing with Section 5775) of Division 5 of the Welfare and Institutions (W&I) Code. Part 2.5 (commencing with Section 5775) of Division 5 of the W&I Code directs the California Department of Mental Health to implement and administer Managed Mental Health Care for Medi-Cal eligible residents of this state; and Los Angeles County Mental Health agrees to operate the Mental Health Plan (MHP) for Los Angeles County. No provision of this contract is intended to obviate or waive any requirements of applicable law or regulation, in particular, the provisions noted above. In the event a provision of this contract is open to varying interpretations, the contract provision shall be interpreted in a manner that is consistent with applicable law and regulation.

4. Successor.

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

5. Definitions.

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

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

B. "Contractor" means .

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

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

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

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

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

H. "MCO" means Managed Care Organization.

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

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

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

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

3) Does not have a comprehensive risk contract.

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

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

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

6. State and Federal Law Governing this Contract.

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

B. Federal Law:

1) Title 42, United States Code;

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

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

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

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

6) Title IX of the Education Amendments of 1972;

7) Age Discrimination Act of 1975;

8) Rehabilitation Act of 1973;

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

10) Deficit Reduction Act of 2005;

11) Balanced Budget Act of 1997.

C. State Law:

1) Division 5, W&I Code;

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

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

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

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

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EXHIBIT A1

Service Delivery, Administrative and Operational Requirements

1. Provision of Services.

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

B. The Contractor shall ensure that all medically necessary Covered Mental Health Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary Covered Mental Health Service solely because of diagnosis, type of illness, or condition of the beneficiary except as specifically provided in the medical necessity criteria applicable to the situation as provided in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210.

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

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

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

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

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

E. The Contractor shall provide out-of-plan services in accordance with Title 9, CCR, Section 1830.220 and Section 1810.365. The timeliness standards specified in Title 9 CCR, Section 1810.405 apply to out-of-plan services as well as in-plan services.

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

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

H. For services provided pursuant to Section 3 of this Exhibit, the Contractor shall consider the following ICD-9 diagnoses codes as included. For any other service, the Contractor may consider these codes as included or may require the provider to use DSM IV coding.

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

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

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

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

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

2. Availability and Accessibility of Service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b) Monitor regularly to determine compliance;

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

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

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

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

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

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

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

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

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

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

3. Emergency Psychiatric Condition Reimbursement.

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

B. "Post-stabilization care services" means covered services related to an emergency medical condition that are provided after a beneficiary is stabilized in order to maintain the stabilized condition.

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

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

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

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

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

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

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

4. Provider Selection and Certification.

A. The Contractor shall comply with Title 9, CCR, Section 1810.435, in the selection of providers and shall review its providers for continued compliance with standards at least once every three years.

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

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

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

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

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

G. Structure and operational standards.

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

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

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

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

J. The Contractor may allow an organizational provider to continue delivering covered services to beneficiaries at a site subject to on-site review as part of the recertification process prior to the date of the on-site review,

provided the site is operational and has any required fire clearances. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the recertification of the provider is due.

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

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

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

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

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

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

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

7) The organizational provider has sufficient staff to allow the Contractor to claim federal financial (FFP) participation for the services the organizational provider delivers to beneficiaries, as described in Title 9, CCR, Section 1840, when applicable.

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

9) The organizational provider’s head of service, as defined in Title 9, CCR, Sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.

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

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

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

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

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

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

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

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

L. For organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with Exhibit A1, Section 8.

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

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

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

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

1) The provider makes major staffing changes.

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

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

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

5) There is a change of ownership or location.

6) There are complaints regarding the provider.

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

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

5. Recovery from Other Sources or Providers.

A. The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.

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

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

D. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming federal financial participation for services provided to beneficiaries with other coverage under this contract.

6. Subrogation.

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

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

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

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

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

E. The value of the covered services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount to subcontracted providers or out-of-plan providers for similar services.

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

1) Beneficiary name;

2) 14-digit Medi-Cal number;

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

4) Date of birth;

5) Contractor name;

6) Provider name (if different from Contractor);

7) Dates of service;

8) Diagnosis code and/or description of illness;

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

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

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

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

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

G. The Contractor shall also provide the Department of Health Care Services with the name, address, and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

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

7. Beneficiary Brochure and Provider List.

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

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

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

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

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

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

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

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

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

   e) Procedures for obtaining benefits, including authorization requirements.

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

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

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

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

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

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

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

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

h) Cost sharing, if any.

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

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

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

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

a) The right to hearing;

b) The method for obtaining a hearing; and

c) The rules that govern representation at the hearing.

2) The right to file grievances and appeals.

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

4) The availability of assistance in the filing process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H. The Contractor shall ensure that provider directories:

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

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

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

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

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

8. Requirements for Day Treatment Intensive and Day Rehabilitation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Day treatment intensive shall additionally include:

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

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

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

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

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

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

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

I. The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). There shall be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

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

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

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

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

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

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

9. Therapeutic Behavioral Services.

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

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

C. TBS shall not be provided unless it is necessary to prevent a beneficiary's placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care, or for a beneficiary who has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

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

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

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

1) Client Assessment,

2) Client Plan,

3) Service Authorization Request,

4) Client Assessment Update,

5) Progress Notes – Day Treatment Intensive Services,

6) Progress Notes – Day Rehabilitation Services,

7) Organizational Provider Agreement (Standard Contract).

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

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

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

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

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

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

11. Quality Management (QM) Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. Quality Improvement (QI) Program.

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

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

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

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

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

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

G. QI activities shall include:

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

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

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

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

5) Designing and implementing interventions for improving performance;

6) Measuring effectiveness of the interventions;

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

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

13. Quality Assurance (QA).

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

A. Assessment.

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

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

of functioning, relevant family history and current family information;

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

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

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

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

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

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

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

i) A mental status examination;

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

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

k) Additional clarifying formulation information, as needed.

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

B. Client Plans.

1) Client Plans shall:

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

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

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

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

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

f) Be consistent with the qualifying diagnoses;

g) Be signed (or electronic equivalent) by:

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

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

iii A person representing the Contractor providing services;

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

A. A physician,

B. A licensed/waivered psychologist,

C. A licensed/registered/waivered social worker,

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

E. A registered nurse;

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

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

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

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

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

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

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

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

C. Progress Notes.

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

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

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

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

d) The date the services were provided;

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

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

g) The amount of time taken to provide services;

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

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

a) Every Service Contact:

i Mental Health Services;

ii Medication Support Services;

iii Crisis Intervention;

iv Targeted Case Management;

b) Daily:

i Crisis Residential;

ii Crisis Stabilization (1x/23hr);

iii Day Treatment Intensive; and

c) Weekly:

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

ii Day Rehabilitation;

iii Adult Residential.

D. Other.

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

2) All entries in the client record shall include:

a) The date of service;

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

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

14. Utilization Management (UM) Program.

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

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

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

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

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

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

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

15. Additional Provisions.

A. <u>Books and Records.</u>

The Contractor shall maintain such books and records as are necessary to disclose how the Contractor discharged its obligations under this contract. These books and records shall identify the quantity of covered services

provided under this contract, the quality of those services, the manner and amount of payment made for those services, the beneficiaries who received covered services, the manner in which the Contractor administered the provision of specialty mental health services and the cost thereof.

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

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

B. Transfer of Care.

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

C. Department Policy Letters.

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

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

D. Delegation.

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

16. Beneficiary Problem Resolution Processes.

A. General Provisions.

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

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

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

a) A grievance process;

b) An appeal process; and,

c) An expedited appeal process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5) No provision of a Contractor's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code Section 5520.

B. Grievance Process.

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

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

2) Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Title 9, CCR, Section 1810.230.5.

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

C. Appeal Process.

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

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

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

c) Pursuant to Title 42, CFR, 438.408(a-c), provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe

may be extended by up to 14 calendar days, if the beneficiary requests an extension or the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Title 9, CCR, Section 1810.230.5;

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

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

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

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

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

a) The results of the appeal resolution process;

b) The date that the appeal decision was made;

c) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal.

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

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

D. Expedited Appeal Process.

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

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

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

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

4) Pursuant to Title 42, CFR, Section 438.408(a-c), the Contractor must resolve an expedited appeal and notify the affected parties in writing, no later than three working days after the Contractor receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the Contractor determines that there is need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension

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

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

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

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

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

E. Beneficiary Problem Resolution Processes Established by Providers.

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

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

2) The provider's beneficiary problem resolution process fully complies with this Section of the contract, the relevant provisions of Title 42, CFR, Subpart F, Title 9, CCR, Sections 1850.205 and 1850.209, and depending on processes delegated, Title 9, CCR, Sections 1850.206, 1850.207, and/or 1850.208; and

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

F. Fair Hearing.

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

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

   a) A beneficiary may request a State Fair Hearing.

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

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

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

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

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

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

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

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

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

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

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

G. Expedited Fair Hearing.

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

H. Continuation of Services Pending Fair Hearing Decision.

1) A beneficiary receiving specialty mental health services pursuant to this Chapter shall have a right to file for continuation of specialty mental health services pending the outcome of a fair hearing pursuant to Title 22, Section 51014.2, and Title 9, CCR, Section 1850.215.

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

without prior authorization and the beneficiary files a timely request for fair hearing.

3) Before requesting a state fair hearing, the beneficiary must exhaust the Contractor's problem resolution processes as described in Title 9, CCR, Section 1850.205.

I. Provision of Notice of Action.

Consistent with Title 42, CFR, Section 438.400(b) and Title 9, CCR, Section 1810.200 “Action,” in the case of an MHP, means:

(a) A denial, modification, reduction or termination of a provider's request for MHP payment authorization of a specialty mental health service covered by the MHP.

(b) A determination by the MHP or its providers that the medical necessity criteria in Section 1830.205(b)(1), (b)(2), (b)(3)(C), or 1830.210(a) have not been met and the beneficiary is not entitled to any specialty mental health services from the MHP.

(c) A failure by the MHP to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP; or

(d) A failure by the MHP to act within the timeframes for resolution of grievances, appeals, or the expedited appeals.

Pursuant to Title 42, CFR, Section 438.404(a), the notice of action shall be in writing and shall meet the language and format requirements of Title 42, CFR, Section 438.10(c) and (d). The notice of action shall contain the items specified in Title 42, CFR, Section 438.404(a) and (b) and Title 9, CCR, Sections 1850.210.

1) The Contractor shall provide a beneficiary with a Notice of Action when the Contractor denies or modifies a Contractor payment authorization request from a provider for a specialty mental health service to the beneficiary.

2) When the denial or modification involves a request from a provider for continued Contractor payment authorization of a specialty mental health service or when the Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with Title 22, CCR, Section 51014.1.

3) A Notice of Action is not required when a denial is a non-binding verbal description to a provider of the specialty mental health services that may be approved by the Contractor.

4) A Notice of Action is not required when the Contractor modifies the duration of any approved specialty mental health services as long as the Contractor provides an opportunity for the provider to request Contractor payment authorization of additional specialty mental health services before the end of the approved duration of services.

5) Except as provided in subsection 6 below, a Notice of Action is not required when the denial or modification is a denial or modification of a request for Contractor payment authorization for a specialty mental health service that has already been provided to the beneficiary.

6) A Notice of Action is required when the Contractor denies or modifies a payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor.

7) The Contractor shall deny the Contractor payment authorization request and provide the beneficiary with a Notice of Action when the Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by Title 9, CCR, Sections 1820.220 or 1830.215.

8) The Contractor shall provide the beneficiary with a Notice of Action if the Contractor fails to notify the affected parties of a grievance decision within 60 calendar days, of an appeal decision within 45 days, or of an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to Title 9, CCR, Sections 1850.206, 1850.207 or 1850.208 and the Contractor failed to notify the affected parties of its decision within the extension period, the Contractor shall provide the beneficiary with a Notice of Action.

9) The Contractor shall provide a beneficiary with a Notice of Action if the Contractor fails to provide a specialty mental health service covered by the Contractor within the timeframe for delivery of the service established by the Contractor.

10) The Contractor shall comply with the requirements of Title 42, CFR, Section 438.404(b), and Title 9, CCR, Section 1850.210, regarding the content of Notices of Action and with the following timeframes for mailing of Notices of Action:

a) The written Notice of Action issued pursuant to (1) or (6) above shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the action. A Notice of Action issued pursuant to (2) above shall be provided in accordance with the applicable timelines set forth in Title 22, Section 51014.1 and Title 42, CFR, 431.220(E).

b) The written Notice of Action issued pursuant to (7) or (8) above shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

c) The written Notice of Action issued pursuant to subsection (9) above shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the Contractor expires.

11) When a Notice of Action would not be required as described in (3)-(5) above, the Contractor shall provide a beneficiary with a Notice of Action when the Contractor or its providers determine that the medical necessity criteria in Title 9, CCR, Section 1830.205(b)(1),(b)(2),(b)(3)(C), or 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the Contractor. A Notice of Action is not required when a provider, including the Contractor acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the Contractor, including but not limited to: crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any specialty mental health service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other specialty mental health service covered by the Contractor. The Notice of Action shall, at the election of the Contractor, be hand-delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with Title 9, CCR, Section 1850.210(f)(1), and shall specify the information contained in Title 9, CCR, Section 1850.212(b).

12) For the purpose of this Section, each reference to a Medi-Cal managed care plan in Title 22, Section 51014.1, shall mean the Contractor.

13) For the purposes of this Section, “medical service”, as used in Title 22, Section 51014.1, shall mean specialty mental health services that are subject to prior authorization by a Contractor pursuant to Title 9, CCR, Sections 1820.100 and 1830.100.

14) The Contractor shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to the Department and DHCS.

J. Contents of a Notice of Action.

1) The Notice of Action issued pursuant to Section I of this contract and Title 42, CFR, Section 438.404(b) and Title 9, CCR, Sections 1850.210(a)-(e) and 1850.212, shall contain the following information:

a) The action taken by the Contractor;

b) The reason for the action taken;

c) Citations to the regulations or Contractor payment authorization procedures supporting the action;

d) The beneficiary's right to file an appeal or expedited appeal with the Contractor; and,

e) The circumstances under which an expedited resolution is available, and how to request it; and,

f) Information about the beneficiary's right to request a fair hearing or an expedited fair hearing, including:

i. The method by which a hearing may be obtained;

ii. A statement that the beneficiary may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

iii. An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested; and,

iv. The time limits for requesting a fair hearing or an expedited fair hearing.

2) A Notice of Action issued pursuant to Title 9, CCR, Sections 1850.210(g) and 1850.212(b), relating to denials for lack of medical necessity, shall specify the following:

i. The reason that the medical necessity criteria were not met, including a citation to the applicable regulation;

ii. The beneficiary's options for obtaining care from sources other than the Contractor, if applicable;

iii. The beneficiary's right to request a second opinion on the determination;

iv. The beneficiary's right to file an appeal or expedited appeal with the Contractor; and,

v. The beneficiary's right to request a fair hearing or an expedited fair hearing, including:

A. The method by which a hearing may be obtained;
B. The time period in which the request for a fair hearing or expedited fair hearing must be filed;
C. That the beneficiary may be either self–represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

K. Pursuant to Title 42, CFR, Section 438.404(c), the Contractor shall give notice at least 10 days before the effective date of action when the action is a termination, suspension, or reduction of previously authorized Medi-Cal-covered services, except:

1) The period of advanced notice is shortened to 5 days if probable beneficiary fraud has been verified;

2) The action shall be effective on the date of the Notice under the following circumstances:

a) The death of a beneficiary;

b) Receipt of a signed written beneficiary statement requesting service termination or giving information requiring termination or reduction of services (provided the beneficiary understands that this will be the result of supplying that information);

c) The beneficiary's admission to an institution where he or she is ineligible for further services;

d) The beneficiary's whereabouts are unknown and mail directed to him or her has no forwarding address;

e) Notice that the beneficiary has been accepted for Medicaid services by another local jurisdiction;

f) A change in the beneficiary's physician's prescription for the level of medical care;

g) Endangerment of the safety or health of individuals in the facility; improvement in the resident's health sufficient to allow a more immediate transfer or discharge; urgent medical needs that require a resident's immediate transfer or discharge; or notice that a resident has not resided in the nursing facility for 30 days (but only in adverse actions based on NF transfers).

3) Pursuant to Title 42, CFR, Section 438.404(c)(2), timeframes for notice of action of denial of payment. If payment is denied, the Contractor shall give notice to the beneficiary on the date of the action.

17. Subcontracts.

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

B. All subcontracts shall be in writing.

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

D. Each subcontract shall contain:

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

2) Specification of the services to be provided.

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

4) 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. The subcontract must be subject to full or partial termination if the subcontractor's performance is inadequate.

5) The nondiscrimination and compliance provisions of this contract as described in Exhibit D, Section 6.

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

7) 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, DHCS, HHS, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives. The subcontract shall also state that inspection shall occur 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 state fiscal year in which the subcontract was in effect.

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

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

10) The subcontractor's agreement to comply with the Contractor's policies and procedures on advance directives and the Contractor's obligations for Physician Incentive Plans, if applicable based on the services provided under the subcontract.

11) A requirement that the Contractor's monitor the subcontractor and the subcontractor's obligation to provide a corrective action plan if deficiencies are identified.

18. Program Integrity Requirements.

A. The Contractor shall comply with the provisions of Title 42, CFR, Sections 438.604, 438.606 and 438.608, regarding the certification of accurate data submitted by the Contractor to the State and which require the Contractor to have administrative or management arrangements or procedures designed to guard against fraud and abuse.

B. The Contractor shall comply with the provisions of Title 42, CFR, Section 438.610, which relate to prohibited affiliations with individuals or affiliates of individuals debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under the guidelines implementing Executive Order No. 12549.

C. Pursuant to Title 42, CFR, Section 438.214(d), the Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, or 1156 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.

D. The Contractor shall periodically check the Office of the Inspector General's List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List (S & I List) to prevent employment of, or payments to, any individuals or entities on those lists, and per DMH Letter Number 10-05, this must be satisfied prior to Medi-Cal certification of any individual or organizational provider. If the provider is listed on either the Office of the Inspector General's List of Excluded Individuals/Entities or the Medi-Cal S & I List, the Contractor shall not certify or pay any provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

E. Report. Pursuant to 42 CFR, Section 455.1(a)(1), the Contractor must report fraud and abuse information to the Department.

1) If the Contractor identifies an issue or receives notification of a complaint concerning an incident of possible potential fraud or abuse, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, regarding potential fraud and/or abuse, and develop and implement corrective action, if needed. The majority of potential fraud or abuse issues are expected to be resolved at the Contractor level.

2) If the Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue is egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall report the issue to the Department for review and disposition.
3) The Department is to be notified if the Contractor discontinues a provider contract or disciplines a provider due to a fraud or abuse issue. The Department will, in turn, notify DHCS.

F. Service Verification. Pursuant to Title 42, CFR, Section 455.1(a)(2), the Contractor shall have a way to verify with beneficiaries that services were actually provided.

G. Conflict of Interest. The contract specifies conflict of interest safeguards for officers and employees of the state and local entity, with responsibilities relating to contracts with MCOs and/or to the default enrollment process under the State Plan Amendment option that are at least as effective as the federal safeguards found under Section 27 of the Office of Federal Procurement Policy Act (41 USC 423).

19. Disclosures.

A. Disclosure of 5% or More Ownership Interest:

1) Pursuant to Title 42, CFR, 455.104, Medicaid managed care entities must disclose certain information related to persons who have an ownership or control interest in the managed care entity, as defined in Title 42, CFR, Section 455.101. The parties hereby acknowledge that, because the Contractor is a political subdivision of the State of California, there are no persons who meet such definition, and therefore there is no information to disclose.

a. In the event that, in the future, any person obtains an interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by Contractor, and that interest equals at least 5% of Contractor's property or assets, then Contractor will make the disclosures set forth in i and subsection 2(a).

i. The Contractor will disclose the name, address, date of birth, and Social Security Number of any managing employee, as that term is defined in Title 42, CFR, Section 455.101. However, for purposes of this disclosure, Contractor may use the business address for any member of its Board of Supervisors.

ii. The Contractor shall provide any such disclosure upon execution of this contract, upon its extension or renewal,

and within 35 days after any change in Contractor ownership or upon request of the Department or DHCS.

2) The Contractor shall ensure that its subcontractors/network providers submit the disclosures below to the Contractor regarding the network providers' (disclosing entities') ownership and control. The Contractor's network providers must be required to submit updated disclosures to the Contractor upon submitting the provider application, before entering into or renewing the network providers' contracts, and within 35 days after any change in the subcontractor/network provider's ownership or upon request of the Department or DHCS.

a. What Disclosures Must be Provided:

i. The name and address of any person (individual or corporation) with an ownership or control interest in the network provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;

ii. Date of birth and Social Security Number (in the case of an individual);

iii. Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);

iv. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

v. The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and

vi. The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

3) To Whom Must the Disclosures be Provided. All disclosures must be provided to the Medicaid agency.

B. Disclosures Related to Business Transactions – Contractor must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.

1) The following information must be disclosed:

a) The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,

b) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

2) Contractor must obligate Network Providers to submit the same disclosures regarding network providers' as noted under subsection 1(a) and (b) within 35 days upon request.

C. Disclosures Related to Persons Convicted of Crimes – Contractor shall submit the following disclosures to the Department regarding the Contractor's management:

1) The identity of any person who is a managing employee of the Contractor who has been convicted of a crime related to federal health care programs. (Title 42, CFR, Section 455.106(a)(1), (2).)

2) The identity of any person who is an agent of the Contractor who has been convicted of a crime related to federal health care programs. (Title 42, CFR, Section 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in Title 42, CFR, Section 455.101.

3) The Contractor shall supply the disclosures before entering into the contract and at any time upon the Department‘s request.

4) Network providers should submit the same disclosures to Contractor regarding the network providers' owners, persons with

controlling interest, agents, and managing employees' criminal convictions. Network providers shall supply the disclosures before entering into the contract and at any time upon the Department's request.

20. Medi-Cal Eligibility Data System (MEDS) and MEDS Monthly Extract File (MMEF) Access.

The Contractor shall enter into a Medi-Cal Privacy and Security Agreement (agreement) with the Department prior to obtaining access to MEDS and the MEDS monthly extract file (MMEF). The Contractor agrees to comply with the provisions as specified in the agreement. The County Mental Health Director or his or her authorized designee shall certify annually that Contractor is in compliance with the agreement. Failure to comply with the terms of the agreement will result in the termination of access to MEDS and MMEF.

21. Additional Requirements.

A. The Contractor shall maintain written policies and procedures on advance directives in compliance with the requirements of Title 42, 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. For purposes of this contract, advance directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated as defined in Title 42, CFR, Section 489.100.

B. Physician Incentive Plans. The Contractor shall obtain approval from the Department prior to implementing a Physician Incentive Plan. A Physician Incentive Plan is any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any beneficiary. For purposes of this definition, the words shall have the meanings set forth in Title 42, CFR, section 422.208(a). The Department shall approve the Contractor's request only if the proposed Physician Incentive Plan complies with all applicable federal and state regulations.

1)Pursuant to Title 42, CFR, Section 438.6(h), the Contractor shall comply with the requirements set forth in Title 42, CFR Section 422.208 and Title 42, CFR, Section 422.210.

2) The Contractor may operate a Physician Incentive Plan only if no specific payment can be made directly or indirectly under a Physician

Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

3) When seeking approval from the Department for its Physician Incentive Plan, the Contractor will disclose the following:

a Whether services not furnished by physician/group are covered by incentive plan. No further disclosure required if the Physician Incentive Plan does not cover services not furnished by physician/group;

b The type of incentive arrangement, e.g. withhold, bonus, capitation;

c The percentage of funds withheld or bonus provided (if applicable);

d The size of the panel, and, if patients are pooled, the approved method used for pooling; and,

e If the physician/group is at substantial financial risk, proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

4) If a physician or physician group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual beneficiary surveys.

5) Disclosure to Beneficiaries. The Contractor shall provide information on its Physician Incentive Plan to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a Physician Incentive Plan).

6) Disclosure to Department. If required to conduct beneficiary survey, survey results shall be disclosed to the Department and, upon request, to beneficiaries, per Social Security Administration (SSA) 1903(m)(2)(A)(x); 42 CFR, 422.208; 42 CFR 422.210; 42 CFR 438.6(h); and SSA 1876(i)(8)(A)(ii)(II).

C. Sharing of Information with Beneficiaries. The Contractor shall not prohibit, or otherwise restrict, a licensed, waivered, or registered professional, as defined in Title 9, CCR, Sections 1810.223 and 1810.254, who is acting within the lawful scope of practice (pursuant to Title 42, CFR, Section 438.102(a)(1)), from advising or advocating on behalf of a beneficiary for whom the provider is providing mental health services for any of the following:

1. the beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2. information the beneficiary needs in order to decide among all relevant treatment options;
3. the risks, benefits, and consequences of providing or failing to provide treatment; and
4. 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.

D. Limitation on Services for Moral or Religious Grounds. Pursuant to Title 42, CFR, Section 438.102(a)(2), the Contractor shall not be required to provide, reimburse for, or provide coverage of, a counseling or referral service if the Contractor objects to the service on moral or religious grounds.

E. Pursuant to Title 42, CFR, Section 438.102(b)(1), if the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

1. To the Department
   a) Prior to executing this contract;
   b) Whenever it adopts the policy during the term of the contract; and,
2. Notice shall be consistent with the provisions of Title 42, CFR, Section 438.10; shall be provided to potential beneficiaries before and during enrollment; and provided to beneficiaries within 90 days after adopting the policy with respect to any particular service.

F. Beneficiary Liability for Payment. 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, or 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. Consistent with Title 42, CFR, Section 438.106, 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.

G. The Contractor shall comply with Title 42, CFR Section 438.236(b), which requires it to adopt practice guidelines.
   1) Such guideline shall meet the following requirements:
      (a) They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;
      (b) They consider the needs of the beneficiaries;
      (c) They are adopted in consultation with contracting health care professionals;
      (d) They are reviewed and updated periodically as appropriate;
   2) Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
   3) Contractor shall take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.

H. Health Information System. Pursuant to Title 42, CFR, Section 438.242 and consistent with Title 9, CCR, Section 1810.376, the Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances, and appeals.

The Contractor's health information system shall, at a minimum:

1) Collect data on beneficiary and provider characteristics as specified by the Department, and on services furnished to beneficiaries as specified by the Department;
2) Ensure that data received from providers is accurate and complete by:
   a. Verifying the accuracy and timeliness of reported data;
   b. Screening the data for completeness, logic, and consistency; and
   c. Collecting service information in standardized formats to the extent feasible and appropriate.
3) Make all collected data available to the Department and, upon request, to CMS.

Consistent with Title 9, CCR, Section 1810.376(c), the Contractor's health information system is not required to collect and analyze all elements in electronic formats.

I. Persons with special health care needs for the purposes of this contract are adults who have a serious mental disorder and children with a serious emotional disturbance as defined in Welfare and Institutions Code Section 5600.3. The Contractor shall identify persons with special health care

needs through the administration of surveys in accordance with the Department's Performance Outcome System.

J. Cost Sharing. Pursuant to Title 42, CFR, Section 438.108, any cost sharing imposed on Medicaid beneficiaries shall be in accordance with Title 42, CFR, Sections 447.50 through 447.60.

K. Service Authorization and Notices of Action. Pursuant to Title 42, CFR, Section 431.201, the Contractor shall define service authorization in a manner that at least includes a beneficiary's request for the provision of a service.

22. Exemption from Title 9, CCR, Section 1820.220(l)(5)(B).

A. Pursuant to the exemption under Title 9, CCR, Section 1810.110(d), the Contractor may exempt hospitals from the requirements of Title 9, CCR, Section 1820.220(l)(5)(B) for beneficiaries who are inpatients of the hospital receiving administrative day services as defined in Title 9, CCR, Section 1810.202, if the hospital refers the beneficiary for consideration under the discharge process administered by the Los Angeles County Department of Mental Health's Countywide Resource Management Program (CRM) and the CRM Program accepts the beneficiary for placement consideration under the process. The Contractor shall ensure that the discharge process includes the following components:

1) Documentation by the hospital of the hospital's referral to the CRM in the patient's chart.

2) Submission of any information on the patient's status to the CRM by the hospital.

3) An evaluation of the patient by the CRM that will assign the patient to the CRM waiting list if admission criteria are met or notify the hospital that assignment to the waiting list has been denied.

4) For patients who are assigned CRM waiting list status, documentation by the hospital in the patient's chart of the results of the hospital's weekly contacts with the CRM that include information on bed availability and waiting list status as reported to the hospital by the CRM.

5) When the patient is at the top of the waiting list, notification by the CRM to the hospital that placement has been authorized and the facilities to which the hospital may refer the patient.

6) Reasonable promptness by the hospital in discharging the patient to the facility that will be accepting the patient.

B. Consistent with the exemption provided in subsection A, when the CRM determines that a beneficiary referred by the hospital does not meet CRM admission criteria, the Contractor shall approve the hospital's MHP payment authorization request for administrative days from the date the hospital and the Contractor agree that acute psychiatric inpatient hospital services were no longer necessary for the beneficiary and that placement in an appropriate non-acute residential treatment facility was medically necessary for the beneficiary through the date that the CRM notified the hospital that the beneficiary did not meet the criteria for admission to the CRM. After the date of the notification, the Contractor shall require that the hospital comply with the provisions of Title 9, CCR, Section 1820.220(l)(5)(B) as a condition of continued authorization of administrative days.

C. The Contractor shall inform hospitals that participate in the CRM of the conditions included in this section and shall maintain a list of the participating hospitals and documentation that the information was provided.

EXHIBIT B

Payment Provisions.

1. Budget Contingency Clauses.

A. Federal Budget.

If federal funding for federal financial participation reimbursement in relation to this contract is eliminated or substantially reduced by Congress, the Department and the Contractor each shall have the option to either cancel this contract or propose a contract amendment to address changes to the program required as a result of the elimination or reduction of federal funding.

B. State Budget.

Through June 30, 2012, this program is funded by the State to the extent that the Legislature appropriates funds through the budget process.

On and after July 1, 2012, this program is funded by the State with funds paid to the Contractor from the Local Revenue Fund 2011.

If state funding for this program is eliminated or reduced by an act of the legislature after the effective date of this contract, the Department and the Contractor each shall have the option to either cancel this contract or propose a contract amendment to address changes to the program required as a result of the elimination or reduction of state funding, except that cancellation of the contract by the Contractor is subject to the requirements of Section 5775(d) of the Welfare and Institutions Code.

C. Delayed Federal or State Budget.

Contractor and Department agree to consult on interim measures for program operation that may be required to maintain adequate services to beneficiaries in the event that there is likely to be a delay in the availability of federal funding or enactment of the State Budget.

2. Payment to the Contractor.

A. The Contractor shall receive payment of its Managed Care Allocation for the period April 1, 2012 through June 30, 2012, after funds are appropriated by the Legislature to the Department in item 4440-103-0001 of the Budget Act. Payment of the Managed Care Allocation shall be in

accordance with Section 5778(c) of the Welfare and Institutions Code and based on a formula determined by the Department in consultation with the California Mental Health Directors Association.

B. The Contractor shall also receive payment of its Managed Care Allocation from Mental Health Service Funds for the period April 1, 2012 through June 30, 2012, after funds are appropriated by the Legislature to the Department in item 4440-103-3085 of the Budget Act. Payment of the Managed Care Allocation from Mental Health Service Funds shall be in accordance with Section 5892, subdivision (j)(1) of the Welfare and Institutions Code. These payments are subject to the limit set forth in Section 5892, subdivision (j)(6) of the Welfare and Institutions Code.

C. The Contractor shall receive payment of its Managed Care Allocation from the Local Revenue Fund 2011 for the period July 1, 2012 through December 31, 2012.

D. For the period April 1, 2012 through June 30, 2012, the state share for reimbursement of claims for EPSDT services, and any other claims for services that may include a State reimbursement funding share, shall become available after passage of the State Budget Act and, irrespective of the effective date of this contract, shall be used to fund all services provided since the beginning of the state fiscal year. The Contractor shall receive payment of the State portion for EPSDT services from an allocation in accordance with Section 5892, subdivision (j)(4), of the Welfare and Institutions Code. These payments are subject to the limit set forth in Section 5892, subdivision (j)(6), of the Welfare and Institutions Code.

E. For the period July 1, 2012 through June 30, 2013, the Contractor shall receive payments for the State share for reimbursement of claims for EPSDT services, and any other claims for services that may include a State reimbursement funding share, from the Local Revenue Fund 2011.

F. Pursuant to Section 5713 of the Welfare and Institutions Code, the Department may advance payments from the amounts available for either the Managed Care Allocation or the state share for claims for services provided under this contract. Any advance payment shall be made in the form and manner determined by the Director. Advance payments are subject to the provisions of the Budget Act.

3. Federal Financial Participation.

Nothing in this contract shall limit the Contractor's ability to submit claims for appropriate federal financial participation reimbursement based on actual, total fund expenditures for any covered services or utilization review and administrative costs. In accordance with Section 5718(c) of the Welfare and Institutions Code, the county shall ensure compliance with all requirements necessary for Medi-Cal reimbursement for these services. Claims for federal financial participation reimbursement shall be submitted by the Contractor and shall be sent by the Department to the Department of Health Care Services for adjudication throughout the fiscal year, regardless of when the State Budget is enacted.

4. Cost Reporting.

The Contractor shall submit a fiscal year-end cost report no later than December 31 following the close of each fiscal year unless that date is extended by the Department, in accordance with Welfare and Institutions Code Sections 5664(a) and (b), and 5718(c), and guidelines established by the Department. Data submitted shall be full and complete and the cost report shall be certified by the Contractor's Mental Health Director and one of the following: (1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3)the county's auditor controller, or equivalent. The cost report shall include both Contractor's costs and the cost of its subcontractors, if any. The cost report shall be completed in accordance with instructions contained in the Department's Cost and Financial Reporting System Instruction Manual for the applicable year; however, to the extent that the Contractor disagrees with such instructions, it may raise that disagreement in writing with the Department at the time the cost report is filed, and shall have the right to appeal such disagreement pursuant to procedures developed under Welfare and Institutions Code Section 14171.

In accordance with Section 5655 of the Welfare and Institutions Code, the Department shall provide technical assistance and consultation to the Contractor regarding the preparation and submission of timely cost reports. If the Contractor does not submit the cost report by the reporting deadline, including any extension period granted by the Department, the Department, in accordance with the provisions of Section 5775(e) of the Welfare and Institutions Code, may withhold payments of additional funds until the cost report that is due has been submitted.

5. Audits and Recoupment.

A. When the Department receives notice from CMS of a deferral or offset by CMS or DHCS of payment of FFP in relation to claims by the Contractor, the Department shall notify the Contractor within 30 days of receiving the deferral or offset notice and include the reason for the deferral or offset, if known.

B. Pursuant to Section 14170 of the Welfare and Institutions Code, cost reports submitted to the Department are subject to audit in the manner and form prescribed by the Department. The year-end cost report shall include both Contractor's costs and the costs of its subcontractors, if any. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. In accordance with Section 14170 of the Welfare and Institutions Code, any audit of Contractor's cost report shall occur within three years of the date of receipt by the Department of the final cost report with signed certification by the Contractor's Mental Health Director and one of the following: (1) the Contractor's Chief Financial Officer (or equivalent), (2) an individual who has delegated authority to sign for, and reports directly to the Contractor's Chief Financial Officer, or (3) the county auditor controller, or equivalent. Both signatures are required before the cost report shall be considered final. For purposes of this section, the cost report shall be considered audited once the Department has informed the Contractor of its intent to disallow costs on the cost report.

C. If the adjustments result in the Department owing an amount to the Contractor, payment to the Contractor shall be made in accordance with applicable federal rules for federal funds (invoicing for federal funds). The Department shall invoice DHCS for the federal funds owed to the Contractor within 45 days after the adjustments are final. Consistent with federal law contained in Title 42, U.S.C. Sections 1396b(d)(2)(C) federal funds shall be recouped within 1 year after the issuance of a final audit report containing a final determination that there has been an overpayment of federal funds. In the case of federal fund recoupment, the Department shall send a notice and invoice to the Contractor, giving options for repayment after the adjustments are final. If the Contractor does not respond within the time period specified in the notice, the Department shall offset the recoupment amount from money owed to the Contractor in accordance with the Department's procedures.

D. Any amount of state funds found to be owed to Contractor shall be paid by the Department from currently available State appropriations within 45 days or, if a current appropriation is not available, within 45 days of a new

State appropriation becoming available. If the adjustments result in the Contractor owing an amount to the Department, the Department shall invoice Contractor for repayment of state funds and the Contractor shall have the option of remitting payment to the Department or agreeing to an offset from amounts owed for current claims submitted. In the event that any amount of State funds must be recouped, pursuant to WIC 5717, repayment is to be collected within 30 days.

6. Claims Adjudication Process.

A. In accordance with Section 5718(c) of the Welfare and Institutions Code, claims for federal funds in reimbursement for services shall comply with eligibility and service requirements under applicable federal and state law.

B. The Contractor shall certify each claim submitted to the Department in accordance with Title 9, CCR, Section 1840.112, at the time the claims are submitted to the Department. The Contractor's Chief Financial Officer or his or her equivalent, or an individual with authority delegated by the county auditor-controller, shall sign the certification, declaring, under penalty of perjury, that the Contractor has incurred an expenditure to cover the services included in the claims to satisfy the 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, declaring, 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 Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with Title 42, CFR, Section 438.604.

C. Claims not meeting federal and/or state requirements shall be returned to Contractor as not approved for payment, along with a reason for denial. Claims meeting all HIPAA transaction requirements and certified by the Contractor in accordance with Title 9, CCR, Section 1840.112, shall be processed and submitted by the Department to DHCS within 30 days for adjudication.

D. Good cause justification for late claim submission is governed by regulation (Title 9, CCR, Section 1840.110) and is subject to approval by the Department of Health Care Services.

E. In the event that the Department or the Contractor determines that significant changes must be made relating to either the Department's or the Contractor's claims submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated costs and other impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.

F. 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. The Contractor shall submit service codes from the Health Care Procedure Coding System (HCPCS) published in the most current Mental Health Medi-Cal billing manual.

7. Payment Data Certification.

Contractor shall certify the data it provides to the Department to be used in determining payment of FFP to the Contractor, in accordance with Title 42, CFR, Sections 438.604 and 438.606.

8. System Changes.

In the event changes in federal or state law, including court decisions and interpretations, necessitate significant changes in either the fiscal or program operations, or a significant change in the cost of providing covered services the Department and the Contractor agree to meet and consult, pursuant to Section 5777(c) of the Welfare and Institutions Code, regarding (a) changes required to remain in compliance with the new law or significant changes in existing obligations, (b) projected programmatic and fiscal impacts, (c) necessary contract amendments. To the extent that contract amendments are necessary, the parties agree to act to ensure appropriate amendments are made to accommodate any changes required by law.

9. Administrative Reimbursement.

The Department shall consult and work with Contractor to determine how federal reimbursement can be obtained for additional or unforeseen administration costs. Consistent with federal and state law, the Department shall process and send to DHCS for reimbursement claims for Medi-Cal Administrative Activity submitted by Contractor within 45 days of receipt.

10. Notification of Request for Contract Amendment.

In addition to the provisions in Exhibit D, section 2 below, both parties agree to notify the other party whenever an amendment to this contract is to be requested so that informal discussion and consultation can occur prior to a formal amendment process.

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Exhibit D

Special Provisions

1. Fulfillment of Obligation.

No covenant, condition, duty, obligation, or undertaking continued or made a part of this contract shall 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. 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 shall 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 (or such different period as the parties mutually may set) 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 the 60-day period, and shall be confirmed in writing within five days thereafter. The party proposing any such change shall have the right to withdraw the proposal at 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 of the 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 date the dispute arises. 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, DHCS, 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 its 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, DHCS, or HHS. Authorized agencies shall maintain the confidentiality of such books and records in accordance with applicable laws and regulations.

5. Notices.

Unless otherwise specified in this contract, 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, unless the contract explicitly requires notice to another individual or organizational unit:

Department

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

Contractor

Los Angeles County Mental Health
Marvin J. Southard,, DSW, Mental Health Director
550 S. Vermont Avenue
Los Angeles, CA 90020

6. 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, Sections 1820.205, 1830.205 and/or 1830.210, prior to providing covered services to a beneficiary.

7. Patients' Rights.

The parties to this contract shall comply with applicable laws and regulations relating to patients' rights, including but not limited to Welfare and Institutions Code 5325, Title 9, CCR, Sections 860 through 868, and Title 42, CFR, Section 438.100. The Contractor shall ensure that its subcontractors comply with these provisions.

Pursuant to Title 42, CFR, Section 438.100(a) and Title 42, CFR, Sections 438.100(b)(1) and,(b)(2)), the Contractor shall have written policies regarding the beneficiary rights specified in this section, including the following rights:

A. Each beneficiary is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

B. Each beneficiary is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.

C. Each beneficiary is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

D. Each beneficiary is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

E. Each beneficiary is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, Section 164.524 and 164.526.

F. Pursuant to Title 42, CFR, Section 438.100(c), the parties acknowledge and agree that each beneficiary is free to exercise his or her rights, and the exercise of those rights will not adversely affect the way the Contractor and its providers or the Department treat the beneficiary.

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

9. Waiver of Default.

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

10. Additional Provisions.

A. The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act (18 U.S.C. Section 874 and 40 U.S.C. Section 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. Section 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 the Davis-Bacon Act, as amended (40 U.S.C. Section 276a to a-7), which provides 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. Section 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. Section 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. Sections 327-333), as supplemented by Department of Labor regulations (Title 29, CFR, Part 5).

D. The Contractor shall comply with the provisions of the Clean Air Act (42 U.S.C. Section 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. Section 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 federal Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency.

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EXHIBIT E

Additional Provisions.

1. Term and Termination.

A. Contract Renewal.

This contract may be renewed unless good cause is shown for non-renewal pursuant to Title 9, CCR, Section 1810.321. This contract shall be renewed every three years.

B. Contract Termination.

The Department or the Contractor may terminate this contract in accordance with Title 9, CCR, Section 1810.323.

C. Mandatory Termination.

The Department is required to terminate this contract in accordance with Subdivision (d) of Section 5777 of the Welfare and Institutions Code when circumstances occur as specified in that provision.

The Department shall terminate its contract if the Secretary of the federal Health and Human Services Agency has determined that the Contractor does not meet the requirements for participation in the Medicaid program as provided in Title XIX of the Social Security Act. The Department shall deliver written notice of termination to the Contractor at least 60 calendar days prior to the effective date of termination.

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.

E. When Contractor terminates a subcontract with a provider, Contractor shall make a good faith effort to provide notice of this termination, within 15 days, to the persons that Contractor, based on available information, determines have recently been receiving services from that provider.

2. Duties of the State.

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

A. Payment for Services.

The Department shall make the appropriate payments set forth in Exhibit B and take all available steps to secure and pay FFP to the Contractor, once the Department receives FFP, for claims submitted by the Contractor. The Department shall notify Contractor and allow Contractor an opportunity to comment to the Department when questions are posed by CMS, or when there is a federal deferral, withholding, or disallowance with respect to claims made by the Contractor.

B. Reviews.

The Department shall conduct reviews of access to and quality of care in Contractor's county at least once every three years and issue reports to the Contractor detailing findings, recommendations, and corrective action, as appropriate, pursuant to Title 9, CCR, Sections 1810.380 and 1810.385. The Department shall also arrange for an annual external quality review of the Contractor as required by Title 42, CFR, Section 438.204(d) and Title 9, CCR, Section 1810.380(a)(7).

C. Monitoring for Compliance.

The Department shall monitor the Contractor's operations for compliance with the provisions of this contract, and applicable federal and state law and regulations. Such monitoring activities shall 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, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action. Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to Title 9, CCR, Sections 1810.380 and 1810.385.

D. The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan as defined in Title 9, CCR, Section 1810.221 and 1810.310 . Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to the Contractor within 60 days of the receipt of the Implementation Plan. A

Contractor shall submit proposed changes to its approved Implementation Plan in writing to the Department for review. A Contractor shall submit proposed changes in the policies, processes or procedures that would modify the Contractor's current Implementation Plan prior to implementing the proposed changes. (See Title 9, CCR, Section 1810.310 (b)-(c).)

E. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Title 9, CCR, Section 1810.410. 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 receipt of the plan from the Contractor. If the Department fails to provide a Notice of Approval or Disapproval, the Contractor may implement the plan 60 calendar days from its submission to the Department.

F. 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 A1, Section 4 of this contract. This certification shall be performed 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 conducted 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 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, whichever date is latest.

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 all 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.

G. Distribution of Informing Materials.

The Department shall provide annual notice to all beneficiaries in accordance with Title 42, CFR, Section 438.10(f)(2), and Title 9, CCR, Section 1810.360(c).

H. Sanctions.

The Department shall conduct oversight and impose sanctions on the Contactor for violations of the terms of this contract, and applicable federal and state law and regulations, in accordance with Title 9, CCR, Sections 1810.380 and 1810.385.

I. Notification.

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

J. Performance Measurement.

The Department shall 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 stakeholders.

EXHIBIT F

HIPAA Business Associate Addendum

1. Recitals.

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. Section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 (“the HIPAA regulations”).

B. The Department wishes to disclose to Contractor certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information (“PHI”), including protected health information in electronic media (“ePHI”), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor is the Business Associate of the Department acting on the Department's behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of the Department and creates, receives, maintains, transmits, uses or discloses PHI, ePHI and PI. The Department and Contractor are each a party to this Agreement and are collectively referred to as the "parties.”

D. The purpose of this Exhibit F is to protect the privacy and security of the PHI, ePHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that the Department must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act.

E. The terms used in this Exhibit F, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

2. Definitions.

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations, and under the Information Practices Act, Civil Code section 1798.29.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.

D. Department PHI or PI shall mean Protected Health Information, Electronic Protected Health Information or Personal Information, as defined below, accessed in a database maintained by the Department, received by Contractor from the Department or acquired or created by Contractor in connection with performing the functions, activities and services specified in this Agreement on behalf of the Department. The terms PHI or PI as used in this document shall mean Department PHI or PI.

E. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921 and implementing regulations.

F. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

G. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR Section 160.103.

H. Privacy Rule shall mean the HIPAA Regulations that are found at 45 CFR Parts 160 and 164, subparts A and E.

I. Personal Information (PI) shall have the meaning given to such term in California Civil Code Section 1798.29.

J. Protected Health Information (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR Section 160.103 and as defined under HIPAA.

K. Required by law, as set forth under 45 CFR Section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

L. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

M. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data utilized in complying with this Agreement; or interference with system operations in an information system that processes, maintains or stores PHI or PI.

N. Security Rule shall mean the HIPAA regulations that are found at 45 CFR Parts 160 and 164.

O. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. Section 17932(h), any guidance issued by the Secretary pursuant to such Act and the HIPAA regulations.

3. Terms of Agreement.

A. Permitted Uses and Disclosures of Department PHI by Contractor.

Except as otherwise indicated in this Exhibit F, Contractor may use or disclose Department PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of the Department, provided that such use or disclosure would not violate the HIPAA regulations, if done by the Department. Any such use or disclosure, if not for purposes of treatment activities of a health care provider as defined by the Privacy

Rule, must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR Section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, and the HIPAA regulations.

B. Specific Use and Disclosure Provisions. Except as otherwise indicated in this Exhibit F, Contractor may:

1) **Use and disclose for management and administration**. Use and disclose Department PHI for the proper management and administration of the Contractor business, provided that such disclosures are required by law, or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be 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 Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

2) **Provision of Data Aggregation Services**. Use PHI to provide data aggregation services to the Department to the extent requested by the Department and agreed to by Contractor. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of the Department with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the Department.

C. Prohibited Uses and Disclosures

1) Contractor shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. Section 17935(a) and 45 CFR Section 164.522(a).

2) Contractor shall not directly or indirectly receive remuneration in exchange for Department PHI, except with the prior written consent of the Department and as permitted by 42 U.S.C. Section 17935(d)(2).

D. Responsibilities of Contractor

Contractor agrees:

1) Nondisclosure. Not to use or disclose Department PHI other than as permitted or required by this Agreement or as required by law.

2) Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Department PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of the Department, in compliance with 45 CFR Sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of Department PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR Section 164, subpart C, in compliance with 45 CFR Section 164.316. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Contractor will provide the Department with its current and updated policies upon request.

3) Security. Contractor shall ensure the continuous security of all computerized data systems containing Department PHI or PI and to protect paper documents containing Department PHI or PI. At a minimum, Contractor shall: :

   a) Comply with all of the data system security precautions listed in Attachment A, Business Associate Data Security Requirements with respect to Department PHI;

   b) Achieve and maintain compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of the Department under this Agreement;

   c) Provide a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated

Information Systems, which sets forth guidelines for automated information systems in Federal agencies;

d) Comply with the substantive privacy and security requirements in the Computer Matching and Privacy Protection Act Agreement between the Social Security Administration and the California Health and Human Services Agency (CHHS) and in the Agreement between the Social Security Administration and DHCS, known as the Information Exchange Agreement (IEA Agreement), which are appended as Attachment B and hereby incorporated into this Agreement. The specific sections of the IEA Agreement with substantive privacy and security requirements which are to be complied with are in the following sections, E, Security Procedures, F. Contractor/Agent Responsibilities, and G, Safeguarding and Reporting Responsibilities for Personally Identifiable Information ("PII"), and in Attachment 4 to the IEA, Electronic Information Exchange Security Requirements, Guidelines and Procedures for Federal, State and Local Agencies Exchanging Electronic Information with the Social Security Administration.

e) In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Contractor must comply within a reasonable period of time with changes to these standards that occur after the effective date of this Agreement.

f) Contractor shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with the Department.

E. Mitigation of Harmful Effects. To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Department PHI by Contractor or its subcontractors in violation of the requirements of this Exhibit F.

F. Contractor's Agents and Subcontractors.

1) To enter into written agreements with any agents, including subcontractors and vendors, to whom Contractor provides

Department PHI or PI that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Contractor with respect to such PHI and PI under this Exhibit F, and that comply with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Contractor shall incorporate, when applicable, the relevant provisions of this Exhibit F into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Contractor.

2) In accordance with 45 CFR Section 164.504(e)(1)(ii), upon Contractor's knowledge of a material breach or violation by its subcontractor of the agreement between Contractor and the subcontractor, Contractor shall:

a) Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by the Department; or

b) Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

G. Availability of Information to the Department and Individuals to Provide Access and Information:

1) To provide access as the Department may require, and in the time and manner designated by the Department (upon reasonable notice and during Contractor's normal business hours) to PHI in a Designated Record Set, to the Department (or, as directed by the Department), to an Individual, in accordance with 45 CFR Section 164.524. Designated Record Set means the group of records maintained for the Department that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for Department health plans; or those records used to make decisions about individuals on behalf of the Department. Contractor shall use the forms and processes developed by the Department for this purpose and shall respond to requests for access to records transmitted by the Department within fifteen (15)

calendar days of receipt of the request by producing the records or verifying that there are none.

2) If Contractor maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Contractor shall provide such information in an electronic format to enable the Department to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. Section 17935(e). This section shall be effective as of the date that 42 U.S.C. Section 17935(e) and its implementing regulations apply to the Department.

3) If Contractor receives data from the Department that was provided to the Department by the Social Security Administration, upon request by the Department, Contractor shall provide the Department with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

H. **Amendment of Department PHI**. To make any amendment(s) to Department PHI that were requested by a patient and that the Department directs or agrees should be made to assure compliance with 45 CFR Section 164.526., in the time and manner designated by the Department, with the Contractor being given a minimum of twenty (20) days within which to make the amendment.

I. **Internal Practices**. To make Contractor's internal practices, books and records relating to the use and disclosure of Department PHI available to the Department or to the Secretary, for purposes of determining the Department's compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Contractor, Contractor shall provide written notification to the Department and shall set forth the efforts it made to obtain the information.

J. **Documentation of Disclosures**. To document and make available to the Department or (at the direction of the Department) to an Individual such disclosures of Department PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR Section 164.528 and 42 U.S.C. Section 17935(c). If Contractor maintains electronic health records for the Department as of January 1, 2009, Contractor must provide an accounting of disclosures, including

those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Contractor acquires electronic health records for the Department after January 1, 2009, Contractor must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting. This section shall be effective only as of the date that 42 USC section 17935(c) and its implementing regulations apply to the Department.

K. **Breaches and Security Incidents.** During the term of this Agreement, Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Initial Notice to the Department.** (1) To notify the Department **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to the Department by the Social Security Administration. (2) To notify the Department **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

   Notice shall be provided to the Department Program Contract Manager and the Department Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the Department Information Security Officer. Notice shall be made using the DHCS “Privacy Incident Report” form, including all information known at the time. Contractor shall use the most current version of this form, which is posted on the DHCS Information Security Officer website (www.dhcs.ca.gov, then select “Privacy” in the left column and then “Business Use” near the

middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Contractor shall take:

a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2. **Investigation and Investigation Report**. To immediately investigate such suspected security incident, security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Contractor shall submit an updated "Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the Department Program Contract Manager and the Department Information Security Officer:

3. **Complete Report**. To provide a complete report of the investigation to the Department Program Contract Manager and the Department Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If the Department requests information in addition to that listed on the "Privacy Incident Report" form, Contractor shall make reasonable efforts to provide the Department with such information. If, because of the circumstances of the incident, Contractor needs more than ten (10) working days from the discovery to submit a complete report, the Department may grant a reasonable extension of time, in which case Contractor shall submit periodic updates until the complete report is submitted. If necessary, a Supplemental Report may be used to submit revised

or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "Privacy Incident Report" form. The Department will review and approve the determination of whether a breach occurred and individual notifications are required, and the corrective action plan.

4. **Notification of Individuals**. If the cause of a breach of PHI or PI is attributable to Contractor or its subcontractors, agents or vendors, Contractor shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The Department Program Contract Manager and the Department Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made. The Department will provide its review and approval expeditiously and without unreasonable delay.

5. **Responsibility for Reporting of Breaches.** If the cause of a breach of PHI or PI is attributable to Contractor or its agents, subcontractors or vendors, Contractor is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Contractor shall notify the Secretary of the breach immediately upon discovery of the breach. If Contractor has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to the Department in addition to Contractor, Contractor shall notify the Department, and the Department and Contractor may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

6. **Department Contact Information**. To direct communications to the above referenced Department staff, the Contractor shall initiate contact as indicated herein. The Department reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an

amendment to this Addendum or the Agreement to which it is incorporated.

Contractor shall use the following contact information up to and including June 30, 2012:

Department Program Contract Manager	**DMH Information Security Officer**
See the Exhibit A, Scope of Work for Program Contract Manager information	Information Security Officer California Department of Mental Health 1600 9th Street, Room 150 Sacramento, CA 95814 Phone: (916) 651-6776 Email: iso@dmh.ca.gov Fax: (916) 651-1341

Contractor shall use the following contact information on July 1, 2012, and thereafter:

Department Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Exhibit A, Scope of Work for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Service Desk (916) 440-7000 or (800) 579-0874 Fax: (916) 440-5537

L. Termination of Agreement. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Contractor knows of a material breach or violation by the Department of this Exhibit F, it shall take the following steps:

1) Provide an opportunity for the Department to cure the breach or end the violation and terminate the Agreement if the Department does not cure the breach or end the violation within the time specified by Contractor; or

2) Immediately terminate the Agreement if the Department has breached a material term of the Exhibit F and cure is not possible.

M. **Due Diligence.** Contractor shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Exhibit F and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Exhibit F.

N. **Sanctions and/or Penalties**. Contractor understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Contractors may result in the imposition of sanctions and/or penalties on Contractor under HIPAA, the HITECH Act and the HIPAA regulations.

4. Obligations of the Department.

The Department agrees to:

A. **Permission by Individuals for Use and Disclosure of PHI**. Provide the Contractor with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Contractor's permitted or required uses and disclosures.

B. **Notification of Restrictions**. Notify the Contractor of any restriction to the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR Section 164.522, to the extent that such restriction may affect the Contractor's use or disclosure of PHI.

C. **Requests Conflicting with HIPAA Rules**. Not request the Contractor to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by the Department.

5. Audits, Inspection and Enforcement

A. From time to time, and subject to all applicable federal and state privacy and security laws and regulations, the Department may conduct a reasonable inspection of the facilities, systems, books and records of Contractor to monitor compliance with this Exhibit F. Contractor shall promptly remedy any violation of any provision of this Exhibit F. The fact that the Department inspects, or fails to inspect, or has the right to inspect, Contractor's facilities, systems and procedures does not relieve Contractor of its responsibility to comply with this Exhibit F. The Department's failure to detect a non-compliant practice, or a failure to report a detected non-

compliant practice to Contractor does not constitute acceptance of such practice or a waiver of The Department's enforcement rights under this Agreement, including this Exhibit F.

B. If Contractor is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Exhibit F, Contractor shall notify the Department. Upon request from the Department, Contractor shall provide the Department with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Contractor is responsible for any civil penalties assessed due to an audit or investigation of Contractor, in accordance with 42 U.S.C. Section 17934(c).

6. Termination.

A. **Term.** The Term of this Exhibit F shall extend beyond the termination of the Agreement and shall terminate when all Department PHI is destroyed or returned to the Department, in accordance with 45 CFR Section 164.504(e)(2)(ii)(I).

B. **Termination for Cause**. In accordance with 45 CFR Section 164.504(e)(1)(ii), upon the Department's knowledge of a material breach or violation of this Exhibit F by Contractor, the Department shall:

1) Provide an opportunity for Contractor to cure the breach or end the violation and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by the Department; or

2) Immediately terminate this Agreement if Contractor has breached a material term of this Exhibit F and cure is not possible.

C. **Judicial or Administrative Proceedings**. Contractor will notify the Department if it is named as a defendant in a criminal proceeding for a violation of HIPAA. The Department may terminate this Agreement if Contractor is found guilty of a criminal violation of HIPAA. The Department may terminate this Agreement if a finding or stipulation that the Contractor has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Contractor is a party or has been joined. DHCS will consider the nature and seriousness of the violation in deciding whether or not to terminate the Agreement.

D. **Effect of Termination**. Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all Department PHI that Contractor still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Contractor shall notify the Department of the conditions that make the return or destruction infeasible, and the Department and Contractor shall determine the terms and conditions under which Contractor may retain the PHI. Contractor shall continue to extend the protections of this Exhibit F to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to Department PHI that is in the possession of subcontractors or agents of Contractor.

7. Miscellaneous Provisions.

A. **Disclaimer**. The Department makes no warranty or representation that compliance by Contractor with this Exhibit F, HIPAA or the HIPAA regulations will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized use or disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of the Department PHI.

B. **Amendment**. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Exhibit F may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of Department PHI. Upon the Department's request, Contractor agrees to promptly enter into negotiations with the Department concerning an amendment to this Exhibit F embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. The Department may terminate this Agreement upon thirty (30) days written notice in the event:

1) Contractor does not promptly enter into negotiations to amend this Exhibit F when requested by the Department pursuant to this section; or

2) Contractor does not enter into an amendment providing assurances regarding the safeguarding of Department PHI that the Department

deems is necessary to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. **Assistance in Litigation or Administrative Proceedings**. Contractor shall make itself and any subcontractors, employees or agents assisting Contractor in the performance of its obligations under this Agreement, available to the Department at no cost to the Department to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Department, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Contractor, except where Contractor or its subcontractor, employee or agent is a named adverse party.

D. **No Third-Party Beneficiaries**. Nothing express or implied in the terms and conditions of this Exhibit F is intended to confer, nor shall anything herein confer, upon any person other than the Department or Contractor and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. **Interpretation**. The terms and conditions in this Exhibit F shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Exhibit F shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. **Regulatory References**. A reference in the terms and conditions of this Exhibit F to a section in the HIPAA regulations means the section as in effect or as amended.

G. **Survival.** The respective rights and obligations of Contractor under Section 6, Item D of this Exhibit F shall survive the termination or expiration of this Agreement.

H. **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Attachment A

Business Associate Data Security Requirements

I. Personnel Controls

A. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of the Department, or access or disclose Department PHI or PI must complete information privacy and security training, at least annually, at Contractor's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of this Agreement.

B. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. Confidentiality Statement. All persons that will be working with Department PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to Department PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for Department inspection for a period of six (6) years following termination of this Agreement.

D. Background Check. Before a member of the workforce may access Department PHI or PI, a background screening of that worker must be conducted. The screening should be commensurate with the risk and magnitude of harm the employee could cause, with more thorough screening being done for those employees who are authorized to bypass significant technical and operational security controls. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years.

2. Technical Security Controls

A. Workstation/Laptop encryption. All workstations and laptops that store Department PHI or PI either directly or temporarily must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as

Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the Department Information Security Office.

B. **Server Security.** Servers containing unencrypted Department PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. **Minimum Necessary.** Only the minimum necessary amount of Department PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. **Removable media devices.** All electronic files that contain Department PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. **Antivirus software.** All workstations, laptops and other systems that process and/or store Department PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. **Patch Management.** All workstations, laptops and other systems that process and/or store Department PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release. Applications and systems that cannot be patched within this time frame due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Applications and systems that cannot be patched must have compensatory controls implemented to minimize risk, where possible.

G. **User IDs and Password Controls.** All users must be issued a unique user name for accessing Department PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed at least every 90

days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

1) Upper case letters (A-Z)
2) Lower case letters (a-z)
3) Arabic numerals (0-9)
4) Non-alphanumeric characters (punctuation symbols)

H. Data Destruction. When no longer needed, all Department PHI or PI must be wiped using the Gutmann or US Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the Department Information Security Office.

I. System Timeout. The system providing access to Department PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. Warning Banners. All systems providing access to Department PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for Department PHI or PI, or which alters Department PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If Department PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. Access Controls. The system providing access to Department PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. Transmission encryption. All data transmissions of Department PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing Department PHI can be encrypted. This requirement pertains

to any type of Department PHI or PI in motion such as website access, file transfer, and E-Mail.

N. **Intrusion Detection**. All systems involved in accessing, holding, transporting, and protecting Department PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3. Audit Controls

A. **System Security Review.** Contractor must ensure audit control mechanisms that record and examine system activity are in place. All systems processing and/or storing Department PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. **Log Reviews.** All systems processing and/or storing Department PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. **Change Control.** All systems processing and/or storing Department PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

4. Business Continuity / Disaster Recovery Controls

A. **Emergency Mode Operation Plan.** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of Department PHI or PI held in an electronic format in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. **Data Backup Plan.** Contractor must have established documented procedures to backup Department PHI to maintain retrievable exact copies of Department PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore Department PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of Department data.

5. Paper Document Controls

A. Supervision of Data. Department PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. Department PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. Escorting Visitors. Visitors to areas where Department PHI or PI is contained shall be escorted and Department PHI or PI shall be kept out of sight while visitors are in the area.

C. Confidential Destruction. Department PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. Removal of Data. Only the minimum necessary Department PHI or PI may be removed from the premises of the Contractor except with express written permission of the Department. Department PHI or PI shall not be considered "removed from the premises" if it is only being transported from one of Contractor's locations to another of Contractors locations.

E. Faxing. Faxes containing Department PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. Mailing. Mailings containing Department PHI or PI shall be sealed and secured from damage or inappropriate viewing of such PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of Department PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of the Department to use another method is obtained.