

**Exhibit E
 ADDITIONAL PROVISIONS**

1. Additional Incorporated Exhibits

A. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit A, Attachment 9	Documentation Requirements	7 page(s)
2) Exhibit A, Attachment 10	Coordination And Continuity Of Care	2 page(s)
3) Exhibit A, Attachment 11	Information Requirements	10 pages
4) Exhibit A, Attachment 12	Beneficiary Problem Resolution	21 page
5) Exhibit A, Attachment 13	Program Integrity	7 pages
6) Exhibit A, Attachment 14	Reporting Requirements	3 pages
7) Exhibit B	Budget Detail And Payment Provisions	5 pages
8) Exhibit C *	General Terms And Conditions	GTC 04/2017
9) Exhibit D (F)	Special Terms And Conditions (Attached hereto as part of this agreement) (Notwithstanding Provisions 2, 3, 4, 6 ,8, 12, 14, 22, 25, 29, and 30 which do not apply to this agreement.)	26 pages
10) Exhibit E	Additional Provisions (Program Terms And Conditions)	16 pages
11) Exhibit E, Attachment 1	Definitions	4 pages
12) Exhibit E, Attachment 2	Service Definitions	6 pages
13) Exhibit F	HIPAA Business Associate Addendum	27 pages
14) Exhibit F, Attachment B	Information Security Exchange Agreement between the Social Security Administration (SSA) and the California Department of Health Care Services (DHCS)	101 pages

2. Amendment Process

Should either party, during the term of this Contract, desire a change or amendment to the terms of this Contract, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether

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the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

3. Cancellation/Termination

A. General Provisions

- 1) As required by, if the Contractor decides not to contract with the Department, does not renew its contract, or is unable to meet the standards set by the Department, the Contractor agrees to inform the Department of this decision in writing. (Welf. & Inst. Code § 14712(c)(1).)
- 2) If the Contractor is unwilling to contract for the delivery of specialty mental health services or if the Department or Contractor determines that the Contractor is unable to adequately provide specialty mental health services or that the Contractor does not meet the standards the Department deems necessary for a mental health plan, the Department shall ensure that specialty mental health services are provided to Medi-Cal beneficiaries. (Welf. & Inst. Code § 147122(c)(2), (3).)
- 3) The Department may contract with qualifying individual counties, counties acting jointly, or other qualified entities approved by the Department for the delivery of specialty mental health services in any county that is unable or unwilling to contract with the Department. The Contractor may not subsequently contract to provide specialty mental health services unless the Department elects to contract with the Contractor. (Welf. & Inst. Code § 147122(c)(4).)
- 4) If the Contractor does not contract with the Department to provide specialty mental health services, the Department will work with the Department of Finance and the Controller to obtain funds from the Contractor in accordance with Government (Govt.) Code 30027.10. (Welf. & Inst. Code § 147122(d).)

A. Contract Renewal

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- 1) This contract may be renewed if the Contractor continues to meet the statutory and regulatory requirements governing this contract, as well as the terms and conditions of this contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. (42 C.F.R. § 438.708; Welf. & Inst. Code § 14714(b)(1).) The Department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the contract. (Welf. & Inst. Code § 14714(b)(1).)
- 2) In the event the contract is not renewed based on the reasons specified in (1), the Department will notify the Department of Finance, the fiscal and policy committees of the Legislature, and the Controller of the amounts to be sequestered from the Mental Health Subaccount, the Mental Health Equity Account, and the Vehicle License Fee Collection Account of the Local Revenue Fund and the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011, and the Controller will sequester those funds in the Behavioral Health Subaccount pursuant to Govt. Code § 30027.10. Upon this sequestration, the Department will use the funds in accordance with Govt. Code § 30027.10. (Welf. & Inst. Code § 14714(b)(3).)

B. Contract Amendment Negotiations

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 in writing 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 costs 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

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amendment is approved by the Department of General Services, if necessary.

D. Contract Termination

The Department or the Contractor may terminate this contract in accordance with, and within the given timeframes provided in California Code of Regulations, title 9, section 1810.323.

- 1) DHCS reserves the right to cancel or terminate this Contract immediately for cause.
- 2) The term "for cause" shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Contract.
- 3) Contract termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor. The notice shall identify any final performance, invoicing or payment requirements.
- 4) Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel, or if cancellation is not possible reduce, subsequent contract costs.
- 5) In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Contract and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.
- 6) The Department will immediately terminate this Contract if the Department finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons will be subject to reasonable notice to the Contractor of the Department's intent to terminate, as well as notification to affected beneficiaries. (Welf. & Inst. Code § 14714(d).)

E. Termination of Obligations

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- 1) 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.
- 2) 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.

F. 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, California Code of Regulations, title 9, or the processes governing the audit appeals process in Chapter 9 of Division 1, California Code of Regulations, title 9 the Contractor shall follow the Dispute Resolution Process outlined in provision number 15 of Exhibit D(F) which is attached hereto as part of this contract.

4. 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.

5. Additional Provisions

A. Inspection Rights/Record Keeping Requirements

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- 1) Provision number seven (Audit and Record Retention) of Exhibit D(F), which is attached hereto as part of this Contract, supplements the following requirements.
- 2) The Contractor, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. Contractor shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. §§ 438.3(h), 438.230(c)(3)(i-iii).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.
- 3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract, including beneficiary grievance and appeal records identified in Attachment 12, Section 2 and the data, information and documentation specified in 42 Code of Federal Regulations parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion

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of all legal remedies, whichever is later. (42 C.F.R. § 438.3(u); See also § 438.3(h).) Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

B. 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 of Health Care Services
Mental Health Services Division
1500 Capitol Avenue, MS 2702
P.O. Box 997413
Sacramento, CA 95899-7413

Humboldt County Health and Human
Services
720 Wood Street
Eureka, CA 95501

C. Nondiscrimination

- 1) Consistent with the requirements of applicable federal law, such as 42 Code of Federal Regulations, part 438.3(d)(3) and (4), and 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, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability.
- 2) 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,

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

- 3) The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.
- 4) Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to California Code of Regulations, title 9, sections 1820.205, 1830.205 and/or 1830.210, prior to providing covered services to a beneficiary.

D. 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.

E. 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 contract 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.

6. Duties of the State

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In discharging its obligations under this contract, and in addition to the obligations set forth in other parts of 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 California Code of Regulations, title 9, sections 1810.380 and 1810.385. The Department shall also arrange for an annual external quality review of the Contractor as required by 42 Code of Federal Regulations, part 438.350 and California Code of Regulations, title 9, section 1810.380(a)(7).

C. Monitoring for Compliance

When monitoring activities identify areas of non-compliance, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action. Cal. Code Reg., tit. 9, § 1810.380. Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to Cal. Code Reg., tit. 9, § 1810.385.

D. The Contractor shall prepare and submit a report to the Department that provides information for the areas set forth in 42 C.F.R. § 438.66(b) and (c) as outlined in Exhibit A, Attachment 14, Section 7, in the manner specified by the Department.

E. If the Contractor has not previously implemented a Mental Health Plan or Contractor will provide or arrange for the provision of covered benefits to new eligibility groups, then the Contractor shall develop an Implementation

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Plan (as defined in Cal. Code Regs., tit. 9, § 1810.221) that is consistent with the readiness review requirements set forth in 42 Code of Federal Regulations, part 438.66(d)(4), and the requirements of Cal. Code Regs., tit. 9, § 1810.310 (a). (See 42 C.F.R. § 438.66(d)(1), (4).) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to the Contractor within 60 days of the receipt of the Implementation Plan. (Cal. Code Regs., tit. 9, § 1810.310(b).) 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 Cal. Code Regs., tit. 9, § 1810.310 (b)-(c)).

- F. The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to Cal. Code Regs., tit. 9, § 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.
- G. Certification of Organizational Provider Sites Owned or Operated by the Contractor
- 1) The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with California Code of Regulations, title 9, section 1810.435, and the requirements specified in Exhibit A, Attachment 3, Section 6 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 Cal. Code Regs., tit. 9, § 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.

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- 2) 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.
- 3) 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.
- 4) 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 FFP by the Contractor and the Department's tracking of that information.

H. Excluded Providers

- 1) If the Department learns that the Contractor has a prohibited affiliation, as described in Attachment 1, Section 2, the Department:
 - a) Must notify the Secretary of the noncompliance.
 - b) May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
 - c) May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.
 - d) Nothing in this section must be construed to limit or otherwise affect any remedies available to the U.S. under

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sections 1128, 1128A or 1128B of the Act. (42 C.F.R.
§438.610(d).)

I. Sanctions

The Department shall conduct oversight and impose sanctions on the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations, in accordance with Welf. & Inst. Code § 14712(e) and Cal. Code Regs., tit. 9, §§ 1810.380 and 1810.385.

J. Notification

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

K. Performance Measurement

The Department shall measure the Contractor's performance based on Medi-Cal approved claims and other data submitted by the Contractor to the Department using standard measures established by the Department in consultation with stakeholders.

7. State and Federal Law Governing this Contract

- A. Contractor agrees to comply with all applicable federal and state law, including the applicable sections of the state plan and waiver, including but not limited to the statutes and regulations incorporated by reference below in Sections C, E, and F, in its provision of services as the Mental Health Plan. Contractor agrees to comply with any changes to these statutes and regulations that may occur during the contract period and any new applicable statutes or regulations. These obligations shall not apply without the need for a Contract amendment(s). To the extent there is a conflict between federal or state law or regulation and a provision in this contract, Contractor shall comply with the federal or state law or regulation and the conflicting Contract provision shall no longer be in effect.
- B. Contractor agrees to comply with all existing policy letters issued by the Department. All policy letters issued by the Department subsequent to the effective date of this Contract shall provide clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to

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State or federal statutes or regulations, or pursuant to judicial interpretation.

C. Federal law:

- 1) Title 42 United States Code, to the extent that these requirements are applicable;
- 2) 42 C.F.R. to the extent that these requirements are applicable;
- 3) 42 C.F.R. Part 438, Medicaid Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHPs), except for the provisions listed in paragraph D and E, below.
- 4) 42 C.F.R. § 455 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) Americans with Disabilities Act
- 10) Section 1557 of the Patient Protection and Affordable Care Act
- 11) Deficit Reduction Act of 2005;
- 12) Balanced Budget Act of 1997.
- 13) The Contractor shall comply with the provisions of the Copeland Anti-Kickback Act, 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.
- 14) The Contractor shall comply with the provisions of the Davis-Bacon Act, as amended, which provides that, when required by Federal Medicaid program legislation, all construction contracts awarded by

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the Contractor and its subcontractors of more than \$2,000 shall include a provision for compliance with the Davis-Bacon Act as supplemented by Department of Labor regulations.

- 15) The Contractor shall comply with the provisions of the Contract Work Hours and Safety Standards Act, 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 the Contract Work Hours and Safety Standards Act.
- 16) Any applicable federal and state laws that pertain to beneficiary rights.

D. The following sections of 42 Code of Federal Regulations, part 438 are inapplicable to this Contract:

- 1) §438.3(b) Standard Contract Provisions – Entities eligible for comprehensive risk contracts
- 2) §438.3(c) Standard Contract Provisions - Payment
- 3) §438.3(g) Standard Contract Provisions - Provider preventable conditions
- 4) §438.3(o) Standard Contract Provisions - LTSS contract requirements
- 5) §438.3(p) Standard Contract Provisions – Special rules for HIOs
- 6) §438.3(s) Standard Contract Provisions – Requirements for MCOs, PIHPs, or PAHPs that provide covered outpatient drugs
- 7) §438.4 Actuarial Soundness
- 8) §438.5 Rate Development Standards
- 9) §438.6 Special Contract Provisions Related to Payment
- 10) §438.7 Rate Certification Submission

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- 11) §438.8 Medical Loss Ratio Standards
 - 12) §438.9 Provisions that Apply to Non-emergency Medical Transportation
 - 13) §438.50 State Plan Requirements
 - 14) §438.52 Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities
 - 15) §438.56 Disenrollment: requirements and limitations
 - 16) §438.70 Stakeholder engagement when LTSS is delivered through a managed care program
 - 17) 438.74 State Oversight of the Minimum MLR Requirements
 - 18) §438.104 Marketing
 - 19) §438.110 Member advisory committee
 - 20) §438.114 Emergency and Post-Stabilization
 - 21) §438.362 Exemption from External Quality Review
 - 22) §438.700-730 Basis for Imposition of Sanctions
 - 23) §438.802 Basic Requirements
 - 24) §438.810 Expenditures for Enrollment Broker Services
 - 25) §438.816 Expenditures for the beneficiary support system for enrollees using LTSS
- E. Specific provisions of 42 Code of Federal Regulations, part 438 relating to the following subjects are inapplicable to this Contract:
- 1) Long Terms Services and Supports
 - 2) Managed Long Terms Services and Supports
 - 3) Actuarially Sound Capitation Rates

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- 4) Medical Loss Ratio
 - 5) Religious or Moral Objections to Delivering Services
 - 6) Family Planning Services
 - 7) Drug Formularies and Covered Outpatient Drugs
- F. Pursuant to Welfare & Institutions Code section 14704, a regulation or order concerning Medi-Cal specialty mental health services adopted by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000), as in effect preceding the effective date of this section, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by DHCS, or until it expires by its own terms.
- G. State Law:
- 1) Division 5, Welfare & Institutions Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
 - 2) Welf. & Inst. Code §§ 14680-14685.1
 - 3) Welf. & Inst. Code §§ 14700-14726
 - 4) Chapter 7, Part 3, Division 9, Welf. & Inst. Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
 - 5) Cal. Code Regs., tit. 9, § 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services
 - 6) Cal. Code Regs., tit. 22, §§ 50951 and 50953
 - 7) Cal. Code Regs., tit. 22, §§ 51014.1 and 51014.2

**Exhibit E – Attachment 1
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1. The following definitions and the definitions contained in California Code of Regulations, title 9, sections 1810.100-1850.535 shall apply in this contract. If there is a conflict between the following definitions and the definitions in California Code of Regulations, title 9, sections 1810.100-1850.535, the definitions below will apply.
 - A. “Advance Directives” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the healthcare when the individual is incapacitated.
 - B. “Abuse” means, as the term described in, provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)
 - C. “Appeal” means a review by the Contractor of an adverse benefit determination.
 - D. “Beneficiary” means a Medi-Cal recipient who is currently receiving services from the Contractor.
 - E. “Contractor” means Humboldt County Health and Human Services.
 - F. “Covered Specialty Mental Health Services” are defined in Exhibit E, Attachment 2.
 - G. “Department” means the California Department of Health Care Services (DHCS).
 - H. “Director” means the Director of DHCS.
 - I. “Emergency” means a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency (Health & Safety Code § 1797.07).
 - J. “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes an act that

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constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)

- K. “Grievance” means an expression of dissatisfaction about any matter other than adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights regardless of whether remedial action is requested. Grievance includes a beneficiary’s right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400)
- L. “Habilitative services and devices” help a person keep, learn, or improve skills and functioning for daily living. (45 C.F.R. § 156.115(a)(5)(i))
- M. “HHS” means the United States Department of Health and Human Service
- N. “Specialist” means a psychiatrist who has a license as a physician and surgeon in this state and shows evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association, or the American Osteopathic Association. (Cal. Code Regs., tit. 9 § 623.)
- O. A “Network Provider” means any provider, group of providers, or entity that has a network provider agreement with a Mental Health Plan, or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department’s contract with a Mental Health Plan. A network provider is not a subcontractor by virtue of the network provider agreement. (42 C.F.R. § 438.2)
- P. “Out-of-network provider” means a provider or group of providers that does not have a network provider agreement with a Mental Health Plan, or with a subcontractor. (A provider may be “out of network” for one Mental Health Plan, but in the network of another Mental Health Plan.)
- Q. “Out-of-plan provider” has the same meaning as out-of-network provider.
- R. “Provider” means a person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for

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participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

- S. "Overpayment" means any payment made to a network provider by a Mental Health Plan to which the provider is not entitled under Title XIX of the Act or any payment to a Mental Health Plan by a State to which the Mental Health Plan is not entitled to under Title XIX of the Act. (42 C.F.R. § 438.2)
- T. "Physician Incentive Plans" mean 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 plan enrollee.
- U. "PIHP" means Prepaid Inpatient Health Plan. . A Prepaid Inpatient Health Plan is an entity that:
- 1) Provides medical services to beneficiaries under contract with the Department of Health Care Services, 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. (42 C.F.R. § 438.2)
- V. "Rehabilitation" means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries. (California's

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Medicaid State Plan, State Plan Amendment 10-016, Attachment 3.1-A, Supplement 3, p. 2a.)

- W. "Satellite site" means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries fewer 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.
- X. "Subcontract" means an agreement entered into by the Contractor with any of the following:
- 1) 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.
 - 2) "Subcontractor" means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP. Notwithstanding the foregoing, for purposes of Exhibit D(F) the term "subcontractor" shall include network providers.

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1. The Contractor shall provide, or arrange and pay for, the following medically necessary covered Specialty Mental Health Services to beneficiaries of Humboldt County. Services shall be provided based on medical necessity criteria, in accordance with an individualized Client Plan, and approved and authorized according to State of California requirements. Services include:
 - A. Mental Health Services Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:
 - 1) Assessment - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.
 - 2) Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.
 - 3) Therapy - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.
 - 4) Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.
 - 5) Collateral - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited

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to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

- B. Medication Support Services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.
- C. Day Treatment Intensive are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- D. Day Rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

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- E. Crisis Intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.
- F. Crisis Stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- G. Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.
- H. Crisis Residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The CRS programs for adults provide normalized living environments, integrated into residential communities. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.
- I. Psychiatric Health Facility Services—A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated

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general acute care hospital or in outpatient settings. These services are separate from those categorized as "Psychiatric Inpatient Hospital".

- J. Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:
- 1) Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
 - 2) Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
 - 3) Supports the parent/caregiver in meeting their child/youth's needs;
 - 4) Helps establish the CFT and provides ongoing support; and
 - 5) Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community
- K. Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the

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child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Core Practice Model (CPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

- L. Therapeutic Behavioral Services (TBS) are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.
- M. Therapeutic Foster Care (TFC) Services model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized SMHS activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma informed interventions that are medically necessary for the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).
- N. Psychiatric Inpatient Hospital Psychiatric Inpatient Hospital Services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute

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psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHPs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHPs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

- O. Targeted Case Management Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.