

**Exhibit E**  
**ADDITIONAL PROVISIONS**

**1. 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 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.

**2. 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. (W&I 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 members ~~beneficiaries~~. (W&I 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. (W&I 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. (W&I Code § 147122(d).)

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**A. Contract Renewal**

- 1) This contract may be renewed if the Contractor continues to meet the requirements of Chapter 8.9 of Part 3 of Division 9 of the W&I Code and implementing regulatory requirements, 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; W&I 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. (W&I 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. (W&I Code § 14714(b)(2).)

**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

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change mutually agreed to by the parties on the condition that the amendment is approved by the Department of General Services, if necessary.

**C. Contract Termination**

The Contractor may terminate this contract in accordance with, Cal. Code Regs., tit. 9, section 1810.323(a). The Department may terminate this contract in accordance with W&I Code, sections 14197.7, 14714 and Cal. Code Regs., tit. 9, section 1810.323.

- 1) DHCS shall terminate this contract if the United States Secretary of Health and Human Services has determined the Contractor does not meet the requirements for participation in the Medicaid program contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code. (W&I Code § 14197.7(i))
- 2) DHCS reserves the right to cancel or terminate this Contract if DHCS finds that Contractor fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. (W&I Code § 14197.7(a))
- 3) Good cause includes, but is not limited to, a finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required contractor report to the department. (W&I Code § 14197.7(a))
- 4) Contract termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor, unless Contractor appeals the termination, or termination is immediate pursuant to paragraph 8. The notice shall identify any final performance, invoicing or payment requirements.
- 5) Contractor may appeal contract termination pursuant to W&I Code sections 14197.7(l)(2) or section 14714(d).

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- 6) Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel, or if cancelation is not possible reduce, subsequent contract costs.
- 7) 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.
- 8) 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 ~~members~~ ~~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 ~~members~~ ~~beneficiaries~~. (W&I Code § 14714(d).)

**D. Termination of Obligations**

- 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 ~~members~~ ~~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 ~~members~~ ~~beneficiaries~~ prior to such expiration or termination.
- 2) When the Contractor terminates a subcontract with a provider, the Contractor shall make a good faith effort to provide notice of this termination, within 15 days, to the persons that the Contractor, based on available information, determines have recently been receiving services from that provider.

**E. 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

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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.

**3. 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.

**4. Additional Provisions**

**A. Inspection Rights/Record Keeping Requirements**

- 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. The 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

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Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, ~~member~~beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for ~~members~~beneficiaries.

- 3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to the Contractor's or subcontractor's performance under this Contract, including ~~member~~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 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 the Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, ~~member~~beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for ~~members~~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  
Medi-Cal Behavioral Health Division  
1501 Capitol Avenue, MS 2702  
Sacramento, CA 95814

Lake County Behavioral Health  
Services Department  
P.O. Box 1024, Lucerne, CA 95458

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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 members ~~beneficiaries~~, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect any ground protected under federal or state law, including sex, race, color, gender, gender identity, religion, marital status, national origin, ethnic group identification, ancestry, age, sexual orientation, medical condition, genetic information, or mental or physical handicap or disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(3-4); 45 C.F.R. § 92.2; Gov. Code § 11135(a); W&I Code § 14727(a)(3).)
- 2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), prohibiting exclusion, denial of benefits, and discrimination against qualified individuals with a disability in any federally assisted programs or activities, and shall comply with the implementing regulations in Parts 84 and 85 of Title 45 of the C.F.R., as applicable.
- 3) The Contractor shall include the nondiscrimination and compliance provisions of this contract in all subcontracts to perform work under this contract.

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

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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.

**5. Duties of the State**

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 the 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 Cal. Code Regs., tit. 9, section 1810.380, subdivision (a), and W&I Code § 14197.7. 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 Cal. Code Regs., tit. 9, section 1810.380(a)(7).



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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. Failure to comply with required corrective action could lead to civil penalties, as appropriate, pursuant to W&I Code § 14197.7.

- 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 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.

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- 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 Cal. Code Regs., tit. 9, section 1810.435, and the requirements specified in Exhibit A, Attachment 8, Section 8 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 **members** ~~beneficiaries~~, except that on-site review is not required for public school or satellite sites.
  - 2) The Department may allow the Contractor to begin delivering covered services to **members** ~~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 **members** ~~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.

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

I. Sanctions

The Department shall conduct oversight in accordance with Cal. Code Regs., tit. 9, §§ 1810.380(a) and impose sanctions on the Contractor for violations of the terms of this contract, and applicable federal and state law and regulations, or the state plan or approved waivers, or for other good cause in accordance with W&I Code § 14197.7 and guidance issued by the Department pursuant to subdivision (r) of W&I Code § 14197.7.

J. Notification

The Department shall notify ~~members~~ ~~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.

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**6. State and Federal Law Governing this Contract**

- A. The Contractor/Subrecipient Designation: the Contractor is considered a contractor subject to 2 C.F.R Part 200 (45 C.F.R. Part 75).
- B. The Contractor agrees to comply with all applicable federal and state law, including but not limited to the statutes and regulations incorporated by reference below in Sections D, G, and H, and applicable sections of the State Plan, **applicable federal waivers, and applicable Behavioral Health Information Notices (BHINs)** and ~~waiver~~ in its provision of services as the Mental Health Plan. The Contractor agrees to comply with any changes to these statutes, and regulations, **State Plan, federal waivers, and BHINs** that may occur during the contract period. **The Contractor shall also comply** with ~~and~~ any newly applicable statutes, or regulations, **State Plan Amendments, federal waivers, and BHINs that become effective during the contract period**. These obligations shall apply without the need for a Contract amendment(s). To the extent there is a conflict between **the terms of this Contract and any** federal or state law ~~statute~~ or regulation **the State Plan, federal waivers, or BHIN** and a provision in this contract, the Contractor shall comply with the federal or state law ~~statute~~ or regulation, **the State Plan, federal waiver, or BHIN** and the conflicting Contract provision shall no longer be in effect.
- C. The 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 the Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to State or federal statutes or regulations, or pursuant to judicial interpretation.
- D. Federal Laws **Governing this Contract:**
- 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.

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- 4) 42 C.F.R. § 455 to the extent that these requirements are applicable;
- 5) 45 C.F.R. § 92.1 et seq. to the extent these requirements are applicable;
- 6) Title VI of the Civil Rights Act of 1964;
- 7) Title IX of the Education Amendments of 1972;
- 8) Age Discrimination Act of 1975;
- 9) Rehabilitation Act of 1973;
- 10) Americans with Disabilities Act;
- 11) Section 1557 of the Patient Protection and Affordable Care Act;
- 12) Deficit Reduction Act of 2005;
- 13) Balanced Budget Act of 1997;
- 14) 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.
- 15) 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 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.
- 16) 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.

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- 17) Any applicable federal and state laws that pertain to member beneficiary rights.
  - 18) Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS must adjust payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. If the Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if the Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity, and DHCS included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority. DHCS will attempt to provide Contractor with timely notice of the loss of program authority.
- E. 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

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- 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
- 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) §438.106 Liability for Payment
- 20) §438.108 Cost Sharing
- 21) §438.110 Member advisory committee
- 22) §438.114 Emergency and Post-Stabilization
- 23) §438.362 Exemption from External Quality Review
- 24) §438.700-730 Basis for Imposition of Sanctions

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- 25) §438.802 Basic Requirements
  - 26) §438.810 Expenditures for Enrollment Broker Services
  - 27) §438.816 Expenditures for the member ~~beneficiary~~ support system for enrollees using LTSS
- F. 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
  - 4) Medical Loss Ratio
  - 5) Religious or Moral Objections to Delivering Services
  - 6) Family Planning Services
  - 7) Drug Formularies and Covered Outpatient Drugs
- G. Pursuant to W&I 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.
- H. State Laws **Governing this Contract:**
- ~~The Contractor shall comply with all State and federal statutes and regulations, the terms of this Agreement, BHINs, and any other applicable authorities. In the event of a conflict between the terms of this Agreement and a State or federal statute or regulation, or a BHIN, the Contractor shall adhere to the applicable statute, regulation or BHIN.~~
- 1) Division 5, W&I Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
  - 2) W&I Code §§ 14059.5 and 14184.402



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- 3) W&I Code §§ 14680-14685.1
- 4) W&I Code §§ 14700-14727
- 5) Chapter 7, Part 3, Division 9, W&I Code, to the extent that these requirements are applicable to the services and functions set forth in this contract
- 6) Cal. Code Regs., tit. 9, § 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services, except for those regulations that are superseded by BHINs
- 7) Cal. Code Regs., tit. 22, §§ 50951 and 50953
- 8) Cal. Code Regs., tit. 22, §§ 51014.1 and 51014.2

**Exhibit E – Attachment 1  
DEFINITIONS**

1. The following definitions and the definitions contained in Cal. Code Regs., tit. 9, sections 1810.100-1850.535 shall apply in this Contract **unless they are superseded by BHIN. The following definitions shall also apply to this Contract unless they are superseded by BHIN.** If there is a conflict between the following definitions and the definitions in Cal. Code Regs., tit. 9, sections 1810.100-1850.535, the **following** definitions ~~below will~~ apply. If there is a conflict with the following definitions and BHIN, the BHIN shall 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 **member** ~~beneficiary~~ practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)
  - C. **“American Indian/Alaska Native (AI/AN)” – Any person defined in 25 United States Code sections 1603(13), 1603(28), or section 1679(a), or who has been determined eligible as an Indian under 42 CFR section 136.12.**
  - D. “Appeal” means a review by the Contractor of an adverse benefit determination.
  - E. **“Assessment” means a service activity designed to collect information and evaluate the current status of a member's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that member. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards. (State Plan, Supplement 3 to Attachment 3.1-A, page 1 [TN 22-0023].)**
  - F. **“Member** ~~Beneficiary~~ means a Medi-Cal recipient who is currently receiving services from the Contractor.
  - G. “Contractor” means Lake County Behavioral Health Services Department.

**Exhibit E – Attachment 1**  
**DEFINITIONS**

- H. "Covered Specialty Mental Health Services" are defined in Exhibit E, Attachment 2.
- I. "Department" means the California Department of Health Care Services (DHCS).
- J. "Director" means the Director of DHCS.
- K. "Discrimination Grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
- L. "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)
- M. "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 constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)
- N. "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 member's ~~beneficiary's~~ rights regardless of whether remedial action is requested. Grievance includes a member's ~~beneficiary's~~ right to dispute an extension of time proposed by the Contractor to make an authorization decision. (42 C.F.R. § 438.400)
- O. "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))
- P. "HHS" means the United States Department of Health and Human Service
- Q. "Homelessness" means The member ~~beneficiary~~ meets the definition established in section 11434a of the federal McKinney-Vento Homeless

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Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

- R. “Indian Health Care Provider (IHCP)” means a health care program operated by the IHS (“IHS facility”), an Indian Tribe, a Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).
- S. **“Indian Health Service (IHS) facilities” – Facilities and/or health care programs administered and staffed by the federal Indian Health Service.**
- T. “Involvement in child welfare” means the ~~member~~beneficiary has an open child welfare services case, or the ~~member~~beneficiary is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the ~~member~~beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

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- U. “Juvenile justice involvement” means the ~~member~~beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. ~~Members-Beneficiaries~~ who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the “juvenile justice involvement” definition. ~~Members-Beneficiaries~~ on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the “juvenile justice involvement” criteria.
- V. “Managed Care Organization” (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. Part 438, and is: 1) a Federally qualified HMO that meets the advance directives requirements of Subpart I of Part 489 of 42 C.F.R.; or, 2) any public or private entity that meets the advance directive requirements and is determined by the Secretary of Health and Human Services to also meet the following conditions: i) makes the services that it provides to its Medicaid ~~members~~beneficiaries as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid ~~members~~beneficiaries within the area served by the entity, ii) meet the solvency standards of 42 C.F.R. 438.116. (42 C.F.R. § 438.2)
- W. “Medically necessary” or “medical necessity” has the same meaning as set forth in Welfare and Institutions Code section 14059.5. For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.
- X. 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

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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)

- Y. “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.)
- Z. “Out-of-plan provider” has the same meaning as out-of-network provider.
- AA. “Overpayment” means any payment made to a network provider by a Mental Health Plan to which the network 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)
- BB. “Peer Support Specialist” means an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification who meets ongoing education requirements and provides services under the direction of a Behavioral Health Professional. (State Plan, Supplement 3 to Attachment 3.1-A, page 2 [TN 22-0023].)**
- CC. “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 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 **members** ~~beneficiaries~~ by employees of the Mental Health Plan.
- DD. “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.

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- EE. “PIHP” means Prepaid Inpatient Health Plan. A Prepaid Inpatient Health Plan is an entity that:
- 1) Provides medical services to members ~~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 members ~~beneficiaries~~; and
  - 3) Does not have a comprehensive risk contract. (42 C.F.R. § 438.2)
- FF. **“Psychosocial Rehabilitation” means a recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member’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 member. Psychosocial rehabilitation includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a member or a group of members. (State Plan, Supplement 3 to Attachment 3.1-A, page 2a [TN 22-0023].)**
- GG. **“Referral and Linkages” are services and supports to connect a member with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)**

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- HH. **“Significant Change” means when there is an increase or decrease in the amount or types of services that are available, or if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits available through this contract, or when there is a change in the scope of specialty mental health services covered by this contract.**
- II. ~~“Rehabilitation” means a recovery or resiliency focused service activity which addresses a mental health need. 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 Medicaid State Plan, State Plan Amendment 10-016, Attachment 3.1-A, Supplement 3, p. 2a.)~~
- JJ. “Satellite site” means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to **members** ~~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.
- KK. “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.)
- LL. “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.



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- 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.
- MM. “Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)**
- NN. “Treatment Planning” means s a service activity to develop or update a member’s course of treatment, documentation of the recommended course of treatment, and monitoring a member’s progress. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)**
- OO. “Tribal 638 Providers” – Federally recognized Tribes or Tribal organizations that contractor or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.**
- 1) **A Tribal 638 provider enrolled in Medi-Cal as an Indian Health Services- Memorandum of Agreement (IHS-MOA) provider must appear on the “ List of American Indian Health Program Providers” set forth in APL 17-020, Attachment1 in order to qualify for**

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reimbursement as a Tribal 638 Provider under BHIN 22-020.

- 2) A Tribal 638 provider enrolled in Medi-Cal as a Tribal FQHC provider is governed by and must enroll in Medi-Cal consistent with the Tribal FQHC criteria established in the California State Plan, 1 the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the “List of Tribal Federally Qualified Health Center Providers,” which is set forth on Attachment 2 to APL 21-008.

JJ. “Urban Indian Organizations (UIO)” – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of Title 25 of the Code of Federal Regulations.

## Exhibit E – Attachment 2 SERVICE DEFINITIONS

1. The Contractor shall provide, or arrange and pay for, the following covered specialty mental health services to members beneficiaries of Lake County. Services shall be provided as medically necessary and approved and authorized according to State of California requirements. Services include:
  - A. “Mental Health Services” are individual, group, or family-based therapies and interventions that are designed to provide a reduction of the member’s mental or emotional disability, and restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community maintenance of functioning consistent with the goals of recovery, resiliency, learning, development, independent living, and enhanced self-sufficiency and that are not. ~~These services are separate from those provided as components of adult residential services, crisis residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Mental health services may include contact with significant support persons or other collateral if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].) 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.~~
    - 2) ~~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.~~
    - 3) ~~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.~~
    - 4) ~~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. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by~~

## Exhibit E – Attachment 2 SERVICE DEFINITIONS

~~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). 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. **This service activities may includes but are not limited to ~~one or more of the following service components:~~ evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; ~~medication education including~~ instruction in the use, risks and benefits of, and alternatives for medication; ~~treatment planning,~~ 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. ~~Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may be provided face-to-face, by telephone or by telehealth, and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.~~**
- C. “Day Treatment Intensive” ~~is~~ **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 ~~members~~ **beneficiaries who receive services for a minimum of at least three hours per day (half-day) or more than four hours per day (full-day), and lasts less than 24 hours each day.** Service activities may include, but are not limited to, **This service includes one or more of the following service components:** assessment, plan development ~~treatment planning,~~ therapy, and psychosocial rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers. **This service may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Day treatment intensive services must**

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**have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)**

- D. “Day Rehabilitation” services ~~are~~ **is** a structured program **which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.** ~~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~~ This service includes one or more of the following service components: assessment, plan development **treatment planning**, therapy, **and psychosocial** rehabilitation. **(State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)** ~~and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.~~
- E. “Crisis Intervention” **is an unplanned, expedited** service ~~last less than 24 hours and are for, to or on behalf of, a member for~~ **to address** a condition that requires more timely response than a regularly scheduled visit. **Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. It may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Service activities include, but are not limited to, This service includes one or more of the following service components:** ~~assessment, collateral and therapy,~~ **and referral and linkages.** Crisis Intervention services may either be face-to-face or by telephone **or telehealth** ~~with the beneficiary or the beneficiary’s significant support person and may be provided~~ **in a**

## Exhibit E – Attachment 2 SERVICE DEFINITIONS

**clinic setting** or anywhere in the community. **(State Plan, Supplement 3 to Attachment 3.1-A, page 2d [TN 22-0023].)**

- F. “Crisis Stabilization” is **an unplanned, expedited service** lasting less than 24 hours and ~~are for, to~~ or on behalf of, a **member** beneficiary ~~for to~~ **address an urgent** condition that **requiring immediate attention that cannot be adequately or safely addressed in a community setting a more timely response than a regularly scheduled visit.** **The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the member or others, or substantially increase the risk of the member becoming gravely disabled. Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization is an all-inclusive program and no other Rehabilitative Mental Health Services are reimbursable during the same time period this service is reimbursed. Crisis stabilization may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All members receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the member 's needs will be made, to the extent resources are available.** ~~Service activities include but are not limited to~~ **This service includes** one or more of the following **service components**: ~~assessment, collateral, and therapy,~~ **crisis intervention, medication support services, referral and linkages.** ~~Collateral addresses the mental health needs of the member beneficiary to ensure coordination with significant others and treatment providers.~~ **(State Plan, Supplement 3 to Attachment 3.1-A, page 2e [TN 22-0023].)**

- G. “Adult Residential Treatment Services” are **recovery focused** rehabilitative services provided in a non-institutional, residential setting for

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**members** beneficiaries who would be at risk of hospitalization or other institutional placement if they were not **in the** receiving residential treatment **program** services. **The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.** 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 **Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following components:** assessment, **treatment planning** plan development, therapy, **and psychosocial** rehabilitation, and collateral. **(State Plan, Supplement 3 to Attachment 3.1-A, page 2f [TN 22-0023].)** Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

- H. “Crisis Residential **Treatment** Services” **are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term—3 months or less) as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. This service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service.** 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. This service **includes one or more of the following:** follow a social rehabilitation model that integrates aspects of emergency psychiatric care, **assessment, treatment planning, therapy,** psychosocial rehabilitation,

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**and crisis intervention. (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)** ~~milieu therapy, case management and practical social work.~~

- I. **“Psychiatric Health Facility Services” are therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by DHCS. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Services are provided in a psychiatric health facility under a multidisciplinary model and some service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis. Services include the following components: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention.** ~~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 general acute care hospital or in outpatient settings. These services are separate from those categorized as “Psychiatric Inpatient Hospital”. (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)~~
- J. **“Peer Support Services” are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their conditions and the process of recovery. Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with**



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**family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.**

**Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:**

- 1) Educational Skill Building Groups, which are groups provided in a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.**
- 2) Engagement, which means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and supporting members in developing their own recovery goals and processes.**
- 3) Therapeutic Activity, which means structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons. (State Plan, Supplement 3 to Attachment 3.1-A, page 2 [TN 22-0023].)**

- K. "Intensive Care Coordination (ICC)" is a targeted case management service that facilitates assessment of care planning for and coordination of services to **members** beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical criteria to access

## **Exhibit E – Attachment 2 SERVICE DEFINITIONS**

SMHS. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their 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 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/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;
- 2) Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;
- 3) Supports the parent/caregiver in meeting their child'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 to be served in their community.

- L. "Intensive Home Based Services (IHBS)" are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) 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, treatment plan, therapy, rehabilitation and **include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member** collateral. IHBS is provided to **members** beneficiaries under 21

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who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.

- M. “Therapeutic Behavioral Services (TBS)” are intensive, individualized, short-term outpatient treatment interventions for members~~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.
  
- N. “Therapeutic Foster Care (TFC) Services” model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services activities (plan development, rehabilitation and collateral) to children 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. The TFC parent will provide trauma informed interventions that are medically necessary for the child. TFC is intended for children~~youth~~ who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain specialty mental health services 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).
  
- O. “Psychiatric Inpatient Hospital Services” include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to members~~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 members~~beneficiaries~~ who were admitted to the hospital for an acute psychiatric inpatient hospital service and the member’s~~beneficiary’s~~ stay at the hospital must be continued beyond the member’s~~beneficiary’s~~ need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the member~~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

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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 **and FFS/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 **SD/MC and FFS/MC** inpatient hospital services via the SD/MC claiming system.

- P. “Targeted case management” is a service that assists a **member** ~~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 **member** ~~beneficiary~~ access to services and the service delivery system; monitoring of the **member’s** ~~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.
- Q. **“Community-Based Mobile Crisis Intervention Services (also referred to as “Mobile Crisis Services”)” are services that provide rapid response, individual assessment and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile Crisis Services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile Crisis Services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile Crisis Services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral’s participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level. Mobile crisis services are provided**

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**by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Locations may include, but are not limited to, the member's home, school, or workplace, on the street, or where a member socializes. Mobile Crisis Services claimed under this option cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to members experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.**