AMENDMENT NO. 7

TO

CONTRACT NO. MA-042-21011456

FOR

ADMINISTRATIVE SERVICES ORGANIZATION FOR SPECIALTY MENTAL HEALTH AND DRUG MEDI-CAL SUBSTANCE ABUSE SERVICES

This Amendment ("Amendment No. 7") to Contract No. MA-042-21011456 for Administrative Services Organization for Specialty Mental Health and Drug Medi-Cal Substance Abuse Services is made and entered into on July 1, 2025 ("Effective Date") between Carelon Behavioral Health of California, Inc., a California corporation ("Contractor"), with a place of business at 12900 Park Plaza Drive, Cerritos, CA 90703, and the County of Orange, a political subdivision of the State of California ("County"), through its Health Care Agency, with a place of business at 405 W. 5th St., Ste. 600, Santa Ana, CA 92701. Contractor and County may sometimes be referred to individually as "Party" or collectively as "Parties".

RECITALS

WHEREAS, the Parties executed Contract No. MA-042-21011458 for Administrative Services Organization for Specialty Mental Health and Drug Medi-Cal Substance Abuse Services, effective July 1, 2021 through June 30, 2023, in a total amount not to exceed $14,283,643, renewable for three additional one-year periods ("Contract"); and

WHEREAS, the Parties, on or about September 13, 2021, executed Amendment No. 1 to the Contract to correct Contractor DUNS Number and Contractor Tax ID Number and to amend Exhibit A due to budget revisions with no alterations to the scope and services; and

WHEREAS, the Parties, on or about September 15, 2022, executed Amendment No. 2 to the Contract to amend Exhibit A payment provision; and

WHEREAS, the Parties, on or about November 29, 2022, executed Amendment No. 3 to the Contract to increase the Contract's Period One Amount Not to Exceed by $2,030,133 from $7,285,105 to $9,315,238 and to increase the Contract's Period Two Amount Not to Exceed by $4,697,690 from $6,998,538 to $11,696,228, for a total amount not to exceed $21,011,466, and to amend Exhibit A to reflect changes in budget and staffing needs with no alterations to the scope and services; and

WHEREAS, the Parties, on or about May 23, 2023, executed Amendment No. 4 to the Contract to renew the Contract for one year, effective July 1, 2023 through June 30, 2024, in an amount not to exceed $11,880,023, for a total amount not to exceed $32,891,489, to change Contractor's name from Beacon Health Options of California, Inc. to Carelon Behavioral Health of California, Inc., and to amend Paragraph XIV. and Exhibit A of the Contract; and

WHEREAS, the Parties, on or about August 2, 2023, executed Amendment No. 5 to the Contract to decrease the Contract's Period One Amount Not to Exceed by $2,030,133 from $9,315,238 to $7,285,105 and increase the Contract's Period Two Amount Not to Exceed by $2,030,133 from $11,696,228 to $13,726,361, to allow final approved invoices for FY 2022-23 to be processed for payment; and

WHEREAS, the Parties, on or about July 1, 2024, executed Amendment No. 6 to the Contract to renew the Contract for one-year, effective July 1, 2024 through June 30, 2025, in an amount not to exceed $12,201,230, for a total amount not to exceed $45,092,719, to amend Paragraph XVI. and Paragraph XX. of the Contract, to add Paragraph XXXIV. and Paragraph XXXV. to the Contract, and to amend Exhibit A of the Contract; and

WHEREAS, the Parties now desire to enter into this Amendment No. 7 to the Contract to renew the Contract for one-year, effective July 1, 2025 through June 30, 2026, in an amount not to exceed $12,879,534, for a total amount not to exceed $57,972,253, to amend Exhibit A of the Contract, and to change the Contract number from "MA-042-21011458" to "MA-042-21011456".

NOW THEREFORE, the Parties agree to amend the Contract as follows:

1. The Contract is renewed for a term of one (1) year, effective July 1, 2025, through June 30, 2026, in an amount not to exceed $12,879,534, for this renewal term, for a revised total amount not to exceed $57,972,253.
2. Referenced Contract Provisions, Term and Amount Not to Exceed provisions, of the Contract are deleted in their entirety and replaced with the following:

"**Term:** July 1, 2021 through June 30, 2026
Period One means the period from July 1, 2021 through June 30, 2022
Period Two means the period from July 1, 2022 through June 30, 2023
Period Three means the period from July 1, 2023 through June 30, 2024
Period Four means the period from July 1, 2024 through June 30, 2025
Period Five means the period from July 1, 2025 through June 30, 2026

Amount Not to Exceed:

Period One Amount Not to Exceed:	$ 7,285,105
Period Two Amount Not to Exceed:	$13,726,361
Period Three Amount Not to Exceed:	$11,880,023
Period Four Amount Not to Exceed:	$12,201,230
Period Five Amount Not to Exceed:	$12,879,534
TOTAL AMOUNT NOT TO EXCEED:	$57,972,253"

3. The Contract number is changed from "MA-042-21011458" to "MA-042-21011456".

4. Exhibit A, Article I. Common Terms and Definitions, of the Contract is deleted in its entirety and replaced with the following:

" **I. COMMON TERMS AND DEFINITIONS**

A. The Parties agree to the following terms and definitions, and to those terms and definitions which, for convenience, are set forth elsewhere in the Contract.

1. Admission means documentation, by CONTRACTOR, for completion of entry of evaluation services provided to individuals seen in COUNTY and COUNTY-contracted services into IRIS.

2. Behavioral Health Services Act (BHSA) means a voter approved initiative to transform California's behavioral health system. It includes 2 parts; the Behavioral Health Services Act and a multi-billion dollar behavioral health bond for community infrastructure and housing with supportive services. It is also known as "Proposition 1". BHSA replaces the Mental Health Services Act (MHSA).

3. Crisis Assessment Team (CAT) means a twenty-four (24) hour mobile response team that provides services to anyone who has a psychiatric emergency. This program assists law enforcement, social service agencies, and families in providing crisis intervention services for the mentally ill. CAT is a multi-disciplinary program that conducts risk assessments, initiates involuntary hospitalizations, and provides linkage and follow ups for individuals evaluated. There are separate adult and youth CATs.

4. Client or Individual means a person who is referred or enrolled, for services under the Contract who is living with mental or emotional disorders.

5. Closed-loop referral means the people, processes and technologies that are deployed to coordinate and refer Clients to available community resources (i.e., health care, behavioral health services, and/or other support services) and follow-up to verify if services were rendered.

6. Crisis Stabilization Unit (CSU) means a psychiatric crisis stabilization program that operates twenty-four (24) hours a day and serves Orange County residents aged thirteen (13) and older who are experiencing a psychiatric crisis and need immediate evaluation. Individuals receive a thorough psychiatric evaluation, crisis stabilization treatment, and referral to the appropriate level of continuing care. As a designated outpatient facility, the CSU may evaluate and treat individuals for no longer than twenty-three (23) hours and fifty-nine (59) minutes.

7. Diagnosis means identifying the nature of a disorder. When formulating a Diagnosis(es), CONTRACTOR shall use the diagnostic codes as specified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association and/or International Classification of Diseases (ICD) 10. ICD10 diagnoses will be recorded on all IRIS documents, as appropriate.

8. Engagement means the process where a trusting relationship is developed over a short period of time with the goal to link the individual(s) to appropriate services within the community. Engagement is the objective of a successful outreach.

9. Face-to-Face means an encounter between the individual/parent/guardian and CONTRACTOR where they are both physically present. This does not include contact by phone, email, etc., except for Telepsychiatry provided in a manner that meets COUNTY protocols.

10. Integrated Records Information System (IRIS) means ADMINISTRATOR's database system and refers to a collection of applications and databases that serve the needs of programs within COUNTY and includes functionality such as registration and scheduling, laboratory information system, billing and reporting capabilities, compliance with regulatory requirements, electronic medical records, and other relevant applications.

11. Lanterman–Petris–Short (LPS) Act (Cal. Welf & Inst. Code, sec. 5000 et seq.) means guidelines for handling involuntary civil commitment to a mental health institution in the State of California.

12. Licensed Clinical Social Worker (LCSW) means a licensed individual, pursuant to the provisions of Chapter 14 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

13. Licensed Marriage Family Therapist (LMFT) means a licensed individual, pursuant to the provisions of Chapter 13 and Chapter 14 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

14. Licensed Professional Clinical Counselor (LPCC) means a licensed individual, pursuant to the provisions of Chapter 13 and Chapter 16 of the California Business and Professions Code, who can provide clinical service to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

15. Licensed Psychiatric Technician (LPT) means a licensed individual, pursuant to the provisions of Chapter 10 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

16 Licensed Psychologist means a licensed individual, pursuant to the provisions of Chapter 6.6 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

17. Licensed Vocational Nurse (LVN) means a licensed individual, pursuant to the provisions of Chapter 6.5 of the California Business and Professions Code, who can provide clinical services to individuals they serve. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

18. Linkage means when a Client has attended at least one appointment or made one visit to the identified program or service for which the Client has received a referral or to which they have self-referred.

19. Live Scan means an inkless, electronic fingerprint which is transmitted directly to the Department of Justice (DOJ) for the completion of a criminal record check, typically required of employees who have direct contact with the individuals served.

20. Medi-Cal means the State of California's implementation of the federal Medicaid health care program which pays for a variety of medical services for children and adults who meet eligibility criteria.

21. Medical Necessity means diagnosis, impairment, and intervention related criteria as defined in COUNTY's MHP under Medical Necessity for Medi-Cal reimbursed Specialty Mental Health Services.

22. National Provider Identifier (NPI) means the standard unique health identifier that was adopted by the Secretary of HHS Services under HIPAA for health care providers. All HIPAA covered healthcare providers, individuals, and organizations must obtain a NPI for use to identify themselves in HIPAA standard transactions. The NPI is assigned for life.

23. Milestones of Recovery Scale (MORS) means a Recovery scale that COUNTY uses in Adult Mental Health programs. The scale assigns Clients to their appropriate level of care and replaces diagnostic and acuity of illness-based tools.

24. NOABD means Notice of Adverse Beneficiary Determination and refers to a Medi-Cal requirement that informs the Client that he/she is not entitled to any specialty mental health service. COUNTY has expanded the requirement for an NOABD to all individuals requesting an assessment for services and found not to meet the Medical Necessity criteria for specialty Mental Health Services.

25. Notice of Privacy Practices (NPP) means a document that notifies individuals of uses and disclosures of their PHI. The NPP may be made by, or on behalf of, the health plan or health care provider as set forth in HIPAA.

26. Nurse Practioner (NP) means a registered nurse with advanced clinical training and a graduate level degree of education. NPs share many of the same duties as doctors. They perform physical exams, diagnose and treat diseases and other health conditions, and prescribe medication.

27. Outreach means linking individuals to appropriate Mental Health Services within the community. Outreach activities will include educating the community about the services offered and requirements for participation in the various mental health programs within the community. Such activities will result in CONTRACTOR developing their own Referral sources for programs being offered within the community.

28. Medi-Cal Certified Peer Support Specialist means an individual in a paid position who has been through the same or similar recovery process as those being assisted to attain their recovery goals in the CSU. A Medi-Cal Certified Peer Support Specialist practice is informed by personal experience.

29. Program Director means an individual who is responsible for all aspects of administration and clinical operations of the mental health program, including development and adherence to the annual budget. This individual also is responsible for the following: hiring, development and performance management of professional and support staff, and ensuring mental health treatment services are provided in concert with COUNTY and state rules and regulations.

30. Protected Health Information (PHI) means individually identifiable health information usually transmitted through electronic media. PHI can be maintained in any medium as defined in the regulations, or for an entity such as a health plan, transmitted or maintained in any other medium. It is created or received by a covered entity and is related to the past, present, or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present, or future payment for health care provided to an individual.

31. Psychiatrist means an individual who meets the minimum professional and licensure requirements set forth in Title 9, CCR, Section 623, and, preferably, has at least one (1) year of experience treating children and TAY.

32. Quality Improvement Committee (QIC) means a committee that meets quarterly to review one percent (1%) of all "high-risk" Medi-Cal recipients in order to monitor and evaluate the quality and appropriateness of services provided. At a minimum, the committee is comprised of one (1) administrator, one (1) clinician, and one (1) physician who are not involved in the clinical care of the cases.

33. Referral means the process of sending a Client from one service provider to another service provider for health care, behavioral health services, and/or other support services, by electronic transmission, in writing or verbally, regardless of Linkage status.

34. Registered Nurse (RN) means a licensed individual, pursuant to the provisions of Chapter 6 of the California Business and Professions Code, who can provide clinical services to the individuals served. The license must be current and in force and not suspended or revoked. Also, it is preferred that the individual has at least one (1) year of experience treating TAY.

35. Resource Recommendation means the process of providing a Client with one or more suggested resources, without plans and/or an ability to follow up on Linkage status.

36. Self-Referral means when a Client or family member directly contacts a service provider with the goal of receiving services for themselves or a family member, regardless of Linkage status.

37. Seriously Emotionally Disturbed (SED) means children or adolescent minors under the age of eighteen (18) years who have a mental health disorder, as identified in the most recent edition of the DSM and/or the ICD 10, other than a primary substance use disorder or

developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. W&I 5600.3.

38. Severe & Persistent Mental Illness (SPMI) means an adult with a mental health disorder that is severe in degree and persistent in duration, which may cause reduced mental health functioning that interferes substantially with the primary activities of daily living and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. W&I 5600.3.

39. Supervisory Review means ongoing clinical case reviews in accordance with procedures developed by ADMINISTRATOR, to determine the appropriateness of Diagnosis and treatment and to monitor compliance to the minimum ADMINISTRATOR and Medi-Cal charting standards. Supervisory review is conducted by the program/clinic director or designee.

40. Soft Token means the security device which allows an individual user to access COUNTY's computer-based IRIS.

41. Uniform Method of Determining Ability to Pay (UMDAP) means the method used for determining an individual's annual liability for Mental Health Services received from COUNTY mental health system and is set by the State of California.

42. Unit of Service (UOS) means one (1) hour during which services are provided to an individual pursuant to the Contract. Each one (1) hour block that the individual receives crisis stabilization services shall be claimed. Partial blocks of time shall be rounded up or down to the nearest one (1) hour increment except that services provided during the first hour shall always be rounded up.

43. Wellness Recovery Action Plan (WRAP) means a self-help technique for monitoring and responding to symptoms to achieve the highest possible levels of wellness, stability, and quality of life.

B. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Common Terms and Definitions Paragraph of this Exhibit A to the Contract."

5. Exhibit A, Article II. Beneficiary Rights, of the Contract is deleted in its entirety and replaced with the following:

" **II. BENEFICIARY RIGHTS**

A. ADVISEMENT NOTICES

1. CONTRACTOR shall ensure that all Clients, upon request for access into the program, shall be given a link to the Medi-Cal Mental Health Plan and Consumer Handbook, developed by COUNTY.

2. CONTRACTOR shall also assure that Clients are aware of their rights at all times by:

a. Publishing the Beneficiary Rights in provider manuals, which shall be available to all providers.

b. Including a copy of the Beneficiary Rights as an attachment to all written correspondence related to appeals, grievances, and reductions or denials of treatment.

3. CONTRACTOR shall use NOABD forms to notify Clients and Network Providers when services are denied, reduced, or terminated pursuant to Services Paragraph of this Exhibit A to the Contract.

4. CONTRACTOR shall ensure that each Network Provider has posted in a conspicuous area a notice advising Clients of their rights as well as CONTRACTOR's toll-free telephone number and Patients' Rights Contractor availability to initiate an appeal or grievance.

5. All Network Providers' mental health facilities and programs shall have in place a mechanism for Clients to file grievances regarding quality of treatment services issues.

6. COUNTY shall provide its MHP, NPP to CONTRACTOR. CONTRACTOR shall provide the NPP for COUNTY, as the MHP, at the time of the first service provided under the Contract to individuals who are covered by Medi-Cal and have not previously received services at a COUNTY operated clinic. CONTRACTOR shall also provide, upon request, the NPP for COUNTY, as the MHP, to any individual who received services under the Contract.

B. INTERNAL BENEFICIARY PROBLEM RESOLUTION

1. Whenever possible, problems shall be resolved informally with provider at the point of service before CONTRACTOR intervenes. CONTRACTOR shall establish a formal grievance process, in the event informal processes do not yield a resolution.
2. CONTRACTOR shall investigate and resolve grievances when quality of care or services include the following:
    a. Services received from an attending physician during a mental health hospitalization.
    b. Services received from an attending physician in a Board and Care or IMDs within CONTRACTOR's ASO Network.
    c. Services received from CONTRACTOR's own staff.
    d. Services received from any provider listed on the Orange County Mental Health Plan ASO Provider Directory.
3. CONTRACTOR shall forward any other grievances aside from items 2.a. – 2.d. above to the MHP Authority and Quality Management Services (QMS) department for investigation and resolution.
4. CONTRACTOR's Internal Beneficiary Problem Resolution process shall include the designation of an Ombudsman who shall be the person responsible to assist Clients with CONTRACTOR's grievance process.

5. Throughout the grievance process, Client rights shall be maintained, including access to the Patients' Rights Advocates at any point in the process. Clients shall be informed of their right to access the Patients' Rights Advocates at any time.
6. CONTRACTOR shall not penalize or discriminate against Clients for filing a grievance.
7. CONTRACTOR shall document, monitor, and report all expressed dissatisfaction with the quality of treatment services. Grievances regarding the quality of treatment services issues shall initially go to the direct care provider, therapist, facility staff, or other persons involved in the issue at hand. Problems not resolved to Client's satisfaction shall, upon the request of the Client or Network Provider, be reviewed for resolution by CONTRACTOR's Ombudsman. All Network Providers shall be required to have grievance forms available to Clients; provided, however, CONTRACTOR shall also allow Clients to initiate a grievance directly with CONTRACTOR either orally or in writing.

a. CONTRACTOR's Ombudsman shall respond within thirty (30) calendar days from receipt of a standard grievance and respond within 72 hours of an expedited grievance.

b. Within confidentiality parameters, CONTRACTOR's Ombudsman shall consider all relevant information and resources, and shall involve other persons to resolve the grievance.

c. Clients shall also be informed of their right to speak to Patients' Rights Advocates at any time.

8. If CONTRACTOR issues an adverse determination, Client or Client's authorized representative may request an appeal. An appeal shall be resolved by referring the appeal to a CONTRACTOR staff member not involved in the decision-making process of the appeal.

9. CONTRACTOR shall maintain a Grievance and Appeal Log for documentation of dispositions and outcomes of Client grievances and appeals.

a. Such log shall be available upon request and be submitted to ADMINISTRATOR quarterly.

b. CONTRACTOR shall submit quarterly a list of grievances and appeals, by issue, to ADMINISTRATOR.

10. CONTRACTOR shall ensure the Client's care is continued during any formal appeals, in accordance with the guidelines specified in WIC.

C. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Beneficiary Rights Paragraph of this Exhibit A to the Contract."

5. Exhibit A, Article III. Budget, Paragraph A., of the Contract is deleted in its entirety and replaced with the following:

"A. COUNTY shall pay CONTRACTOR in accordance with the Payments Paragraph in this Exhibit A to the Contract and the following budgets, which are set forth for informational purposes only and may be adjusted by mutual agreement, in writing, by ADMINISTRATOR and CONTRACTOR.

	Period One	Period Two	Period Three	Period Four	Period Five	TOTAL
Administrative Cost						
Salaries	$38,904	$41,183	$43,631	$45,159	$46,740	$214,807
Benefits	8,952	14,034	17,016	17,612	18,228	75,842
Services and Supplies	4,793	5,519	5,870	6,046	6,258	28,486
Indirect Cost	668,026	808,476	907,030	1,0000,901	1,201,081	4,858,524
Subtotal Administrative Cost	$719,865	$869,212	$973,547	$1,069,718	$1,272,307	$4,904,649
Program Cost						
Salaries	$3,451,804	$3,445,244	$3,793,046	$4,216,077	$4,526,310	$19,432,482
Benefits	703,074	1,182,321	1,479,288	1,644,270	1,765,261	6,774,214
Services and Supplies	1,084,229	1,189,451	1,234,141	1,271,165	1,315,656	6,094,642
Subtotal Program Cost	$5,239,107	$5,817,016	$6,506,475	$7,131,512	$7,607,227	$32,301,338
Mental Health Claims/Settlement	$2,870,133	$5,010,000	$4,400,000	$4,000,000	$4,000,000	$20,280,133
Implementation Costs	486,133	0	0	0	0	$486,133
Roll-Over Adjustment	<2,030,133>	2,030,133	0	0	0	$0
Total Gross Cost	$7,285,105	$13,726,361	$11,880,023	$12,201,230	$12,879,534	$57,972,253
Revenue						
Fed Grant (DMC)	$437,106	$437,106	$594,001	$610,062	$643,977	$2,722,252
FFP/Other	2,986,893	2,986,893	1,900,804	1,952,197	2,060,725	11,877,512
State	3,788,255	10,229,511	9,385,218	9,638,972	10,174,832	43,216,787
(MH Realignment Managed Care)						
Discretionary (NCC)	72,851	72,851	0	0	0	$145,702
Total Revenue	$7,285,105	$13,726,361	$11,880,023	$12,201,230	$12,879,534	$57,972,253
Total Amount Not To Exceed	$7,285,105	$13,726,361	$11,880,023	$12,201,230	$12,879,534	$57,972,253"

6. Exhibit A, Article V. Payments, of the Contract is deleted in its entirety and replaced with the following:

"**V. PAYMENTS**

A. For Period Five, COUNTY shall pay CONTRACTOR monthly, in arrears, at the negotiated amount of $106,025.58, per month for Indirect Costs and the provisional amount of $633,935.25, per month for Administrative and Program Direct Costs, and the provisional amount of $333,333.50, per month for Mental Health Claims Costs. All payments are interim payments only, and subject to Final Settlement in accordance with the Cost Report Paragraph of the Contract for which CONTRACTOR shall be reimbursed for the actual cost of providing the services hereunder; provided, however, the total of such payments does not exceed COUNTY's Total Amount Not to Exceed as specified in the Referenced Contract Provisions of the Contract and, provided further, CONTRACTOR's costs are reimbursable pursuant to COUNTY, state, and federal regulations. ADMINISTRATOR may, at its discretion, pay supplemental invoices for any month for which the provisional amount specified above has not been fully paid.

1. Payments of claims to providers shall be at rates set by CONTRACTOR, with mutual agreement by ADMINISTRATOR, for all services.

2. In support of the monthly invoice, CONTRACTOR shall submit an Expenditure and Revenue Report as specified in the Reports Paragraph of this Exhibit A to the Contract. ADMINISTRATOR shall use the Expenditure and Revenue Report to determine payment to CONTRACTOR as specified in Subparagraphs A.3. and A.4., below.

3. If, at any time, CONTRACTOR's Expenditure and Revenue Reports indicate that the provisional amount payments exceed the actual cost of providing services, ADMINISTRATOR may reduce payments to CONTRACTOR by an amount not to exceed the difference between the year-to-date provisional amount payments to CONTRACTOR and the year-to-date actual cost incurred by CONTRACTOR.

4. If, at any time, CONTRACTOR's Expenditure and Revenue Reports indicate that the provisional amount payments are less than the actual cost of providing services, ADMINISTRATOR may authorize an increase in the provisional amount payment to CONTRACTOR by an amount not to exceed the difference between the year-to-date provisional amount payments to CONTRACTOR and the year-to-date actual cost incurred by CONTRACTOR.

B. CONTRACTOR's invoices shall be on a form approved or supplied by ADMINISTRATOR and provide such information as is required by ADMINISTRATOR. Invoices are due the tenth (10th) day of each month. Invoices received after the due date may not be paid within the same month. Payments to CONTRACTOR should be released by COUNTY no later than thirty (30) calendar days after receipt of the correctly completed invoice.

C. All invoices to COUNTY shall be supported at CONTRACTOR's facility, by source documentation including, but not limited to, ledgers, journals, time sheets, invoices, bank statements, canceled checks, receipts, receiving records, and records of services provided.

D. CONTRACTOR shall promptly return any overpayments within forty-five (45) business days after the overpayment is verified by ADMINISTRATOR. Payment adjustment will be completed in collaboration with ADMINISTRATOR to determine the mechanism of reimbursement.

E. ADMINISTRATOR may withhold or delay any payment if CONTRACTOR fails to comply with any provision of the Contract.

F. CONTRACTOR shall see that Mental Health Claims are billed within twelve (12) months from date of service (DOS). Any stale dated claims (those over twelve (12) months) shall be the responsibility of CONTRACTOR and not billed to ADMINISTRATOR. CONTRACTOR shall adjudicate any denied claims, either of Network Providers, or DHCS denials of claims, and ensure timely submission of all Mental Health Claims. ADMINISTRATOR will not reimburse for stale dated claims due to billing errors or late submissions of claims. Any stale dated claims that may have been previously reported to and paid by ADMINISTRATOR shall be reimbursed to ADMINISTRATOR as indicated in the Services Paragraph of this Exhibit A to the Contract.

G. COUNTY shall not reimburse CONTRACTOR for services provided beyond the expiration and/or termination of the Contract, except as may otherwise be provided under the Contract, or specifically agreed upon in a subsequent contract.

H. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Payments Paragraph of this Exhibit A to the Contract."

7. Exhibit A, Article VIII. Reports, of the Contract is deleted in its entirety and replaced with the following:

"**VIII. REPORTS**

A. CONTRACTOR shall maintain records, create and analyze statistical reports as required by ADMINISTRATOR and DHCS in a format approved by ADMINISTRATOR.

B. ADMINISTRATOR and CONTRACTOR shall utilize a mutual reports tracking system, the Reporting Deliverables Index (RDI), to track, monitor, audit, and update all required reports submitted by CONTRACTOR. CONTRACTOR shall, upon ADMINISTRATOR's request,

revise and make reasonable changes to existing reports as needed. Any Reports listed in the RDI will be considered contractually required reports to be submitted by CONTRACTOR to ADMINISTRATOR. The RDI will define the name, submission frequency, ADMINISTRATOR department that utilizes the report, specifications, and purpose of each report. This RDI will be reviewed quarterly, or upon request by ADMINISTRATOR and CONTRACTOR, and will include, but not be limited to, the reports listed within this Exhibit A Reports Section.

C. Reports included in the RDI but also requiring additional information in this Exhibit A are listed below. CONTRACTOR shall provide ADMINISTRATOR with the following:

D. FISCAL REPORTS

1. CONTRACTOR shall submit monthly Expenditure and Revenue Reports to ADMINISTRATOR. These reports shall be on a form acceptable to, or provided by, ADMINISTRATOR and shall report actual costs and revenues for CONTRACTOR's program described in the Services Paragraph of this Exhibit A to the Contract. Any changes, modifications, or deviations to any approved budget line item must be approved in advance and in writing by ADMINISTRATOR and annotated on the monthly Expenditure and Revenue Report, or said cost deviations may be subject to disallowance. Such reports shall be received by ADMINISTRATOR no later than twenty (20) calendar days following the end of the month being reported.

2. CONTRACTOR shall provide a check register and remittance summary by provider, as well as a turnaround summary, for services provided by Network Providers, to ADMINISTRATOR upon request.

3. CONTRACTOR shall track and provide IBNR information on a monthly basis. Monthly IBNR shall be calculated and compared with the record of uncashed checks and stop-payment checks, as well as to the undeliverable check report and the donated checks report. CONTRACTOR shall prepare and submit to ADMINISTRATOR a monthly report showing total IBNR liability and revenue received based upon the provisional payments received from COUNTY.

4. CONTRACTOR shall submit Year-End Projection Reports to ADMINISTRATOR. These reports shall be on a form acceptable to, or provided by, ADMINISTRATOR and shall report anticipated year-end actual costs and revenues for CONTRACTOR’s program described in the Services Paragraph of this Exhibit A to the Contract. Such reports shall include actual monthly costs and revenue to date and anticipated monthly costs and revenue to the end of the fiscal year, and shall include a projection narrative justifying the year-end projections. Year-End Projection Reports shall be submitted in conjunction with the Monthly Expenditure and Revenue Reports.

E. STAFFING REPORT – CONTRACTOR shall submit monthly Staffing Reports to ADMINISTRATOR. CONTRACTOR's reports shall contain required information, and be on a form acceptable to, or provided by ADMINISTRATOR. CONTRACTOR shall submit these reports no later than twenty (20) calendar days following the end of the month being reported.

F. PROGRAMMATIC REPORTS – CONTRACTOR shall submit monthly Programmatic reports to ADMINISTRATOR. These reports shall be in a format approved by ADMINISTRATOR and shall include but not limited to, descriptions of any performance objectives, outcomes, and or interim findings as directed by ADMINISTRATOR. CONTRACTOR shall be prepared to present and discuss the programmatic reports at the monthly and quarterly meetings with ADMINISTRATOR, to include an analysis of data and findings, and whether or not CONTRACTOR is progressing satisfactorily and if not, specify what steps are being taken to achieve satisfactory progress.

G. PRIVACY INCIDENT REPORTING – CONTRACTOR shall report all privacy or PHI breach incidents to ADMINISTRATOR within two business days of discovery that have been reported to CONTRACTOR's internal Privacy Analysts.

H. COMPLIANCE REPORTING – CONTRACTOR shall report all compliance incidents to ADMINISTRATOR within two business days of discovery that have been reported to DHCS via the MC 609 Medi-Cal Complaint Report Form.

I. CONTRACTOR's Special Investigation Unit (SIU) shall collaborate with the ADMINISTRATOR's Office of Compliance, and HCA Quality Management Services (QMS) as requested by ADMINISTRATOR. CONTRACTOR's SIU shall provide a monthly report on active compliance incidents. The report shall include content which shall be agreed upon by CONTRACTOR and ADMINISTRATOR. CONTRACTOR's SIU shall provide updates at ADMINISTRATOR's monthly Management Meeting and attend in person if requested by ADMINISTRATOR. Requests for attendance shall be made to CONTRACTOR at least thirty (30) calendar days in advance. In addition, CONTRACTOR shall notify ADMINISTRATOR of resolved cases within ten (10) business days of the resolution. ADMINISTRATOR recognizes that on occasion scheduling or staff absences on CONTRACTOR's part may require accommodation. If ADMINISTRATOR receives financial penalties from State or Federal entities that result from delayed submission of legally required reporting and the cause is determined to be CONTRACTOR's failure to provide timely information to ADMINISTRATOR, the financial penalties will be passed along to CONTRACTOR.

J. CONTRACTOR shall submit monthly records and program reports no later than twenty (20) calendar days following the end of the month being reported or as requested by ADMINISTRATOR.

K. CONTRACTOR shall submit quarterly reports no later than twenty (20) calendar days following the end of the quarter being reported, or as requested by ADMINISTRATOR. The quarter periods are as follows:

Quarter 1 - July 1 through September 30

Quarter 2 - October 1 through December 31

Quarter 3 - January 1 through March 31

Quarter 4 - April 1 through June 30

L. CONTRACTOR shall submit annual reports no later than twenty (20) calendar days following the end of the Fiscal Year.

M. ACCESS LOG – CONTRACTOR shall develop and maintain a written Access Log of all requests for services received via telephone, in writing, or in person. CONTRACTOR is responsible for this written log that meets the DHCS regulations and requirements, as interpreted by COUNTY, and records all services requested twenty-four (24) hours-seven (7) days a week. The Access Log shall contain, at a minimum, whether or not the caller has Medi-Cal, the name of the individual, date of the request, nature of the request, call status (emergent, urgent, routine), if the request is an initial request for Specialty Mental Health Services, and the disposition of the request, which shall include interventions. CONTRACTOR must be able to produce a sortable log, for any time-period specified by COUNTY within twenty-four (24) hours of receiving the request from COUNTY. If the caller's name is not provided, then the log shall reflect that the caller did not provide a name. CONTRACTOR shall make available to ADMINISTRATOR upon request, the most recent telephone log which shall include previous day's calls.

N. DATA COLLECTION AND REPORTING – ADMINISTRATOR shall provide CONTRACTOR with the exact specifications required to enter data into ADMINISTRATOR approved CONTRACTOR reporting system to allow ADMINISTRATOR to create the claims file used for Medi-Cal claiming and for ADMINISTRATOR's CSI data reporting. CONTRACTOR shall submit Medi-Cal 837 claims, voids, and replacements, and CSI files electronically to ADMINISTRATOR. The Parties understand that such requirements may be modified periodically by the State.

1. ADMINISTRATOR shall provide CONTRACTOR with a monthly MEDS Extract file (MMFE) when available from DHCS or as agreed upon by ADMINISTRATOR and CONTRACTOR.

2. CONTRACTOR shall ensure the timely data entry of information into COUNTY approved CONTRACTOR reporting system.

3. CONTRACTOR shall conduct up-front and retrospective auditing of data to ensure the accuracy, completeness, and timeliness of the information input into CONTRACTOR's reporting system. CONTRACTOR shall build in audit trails and reconciliation reports to ensure

accuracy and comprehensiveness of the input data. In addition, transaction audit trails shall be thoroughly monitored for accuracy and conformance to operating procedures.

4. CONTRACTOR shall input all required data regarding services provided to Clients who are deemed, by the appropriate state or federal authorities, to be COUNTY's responsibility.

5. CONTRACTOR shall correct all input data resulting in CSI and 837 Medi-Cal claim denials and rejections. These errors will be communicated to CONTRACTOR immediately upon discovery and must be corrected within thirty (30) business days.

6. CONTRACTOR shall ensure the confidentiality of all administrative and clinical data. This shall include both the electronic system as well as printed public reports. No identifying information or data on the system shall be exchanged with any external entity or other business, or among providers without prior written approval of the Client or ADMINISTRATOR. Confidentiality procedures shall meet all local, state, and federal requirements.

7. CONTRACTOR shall ensure that information is safeguarded in the event of a disaster and that appropriate service authorization and data collection continues.

O. CONTRACTOR shall respond to any requests that are needed with an immediate response time due to any requests from entities that could include but not be limited to DHCS, internal and/or external audits.

P. ADMINISTRATOR and CONTRACTOR may mutually agree, in writing, to modify the frequency of the reports. Each report shall include an unduplicated client count and a fiscal year-to-date summary and, unless otherwise specified, shall be reported in aggregate.

Q. ADDITIONAL REPORTS – Upon ADMINISTRATOR's request, CONTRACTOR shall make such additional reports as required by ADMINISTRATOR concerning CONTRACTOR's activities as they affect the services hereunder. ADMINISTRATOR shall be specific as to the nature of information requested and allow thirty (30) calendar days for CONTRACTOR to respond. In addition to the reports described in Exhibit A and reports mutually agreed to in the RDI, ADMINISTRATOR can request/receive four (4) ad-hoc reports, per contract year, free of charge. Non-standard reports shall be delivered according to a mutually agreed timeline after full specifications are received and confirmed by CONTRACTOR. ADMINISTRATOR will be charged for any additional report requests – baseline charge will be $500.00 but may be higher depending on the report complexity and LOE development. ADMINISTRATOR must approve cost before report is developed/generated.

R. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Reports Paragraph of this Exhibit A to the Contract."

8. Exhibit A, Article IX. Services, of the Contract is deleted in its entirety and replace with the following:

"**IX. SERVICES**

A. FACILITIES: CONTRACTOR shall maintain appropriate facility(ies) for the provision of services described herein at the following location(s), or any other location approved, in advance, in writing, by ADMINISTRATOR. The facility shall include space to support the services identified within the Contract.

Carelon Behavioral Health of California, Inc.
12900 Park Plaza Drive
Cerritos, California 90730

B. ADMINISTRATIVE STAFF SCHEDULE: CONTRACTOR shall provide administrative coverage, Monday through Friday 8:00 a.m. – 5:00 p.m. Pacific Time.

C. PROVIDER NETWORK

1. DEVELOPMENT AND MANAGEMENT

a. CONTRACTOR shall maintain a limited Provider Network, as approved by ADMINISTRATOR and CONTRACTOR, to provide Specialty Mental Health Services at provider's individual offices or facilities, based upon COUNTY assessment needs, including, but not limited to, addressing geographic accessibility and cultural competency, which includes service availability in threshold languages that include English, Spanish, Farsi, Korean, Arabic, Chinese, Russian and Vietnamese. Additional languages required may be added should DHCS designate additional languages as meeting the threshold for language requirements.

b. CONTRACTOR shall provide a range of Network Providers capable of delivering services as set forth by this Contract which may include but is not limited to: psychiatrists; licensed psychiatric nurse practitioners, Licensed Professional of the Healing Arts (LPHA), as determined by DHCS; and other providers as approved by ADMINISTRATOR.

c. CONTRACTOR shall work with ADMINISTRATOR on identifying and then recruiting only those Network Providers who are serving a specialty population, at acute facility level of care, LPS conserved population living in residential settings at County approved facilities, providers treating eating disorder diagnosed clients and Network Providers who are providing specialty services, such as Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), or culturally specific services, or who are in geographic location(s) that would maximize Client access. Such providers shall be pursued to participate in the Provider Network, and their credentialing process shall be expedited in order to maintain limited Provider Network.

d. CONTRACTOR shall work with ADMINISTRATOR on credentialing specified in the Services Paragraph of this Exhibit A to the Contract. Individual, group and organizational providers must meet the following criteria to be a CONTRACTOR Network Provider:

1) Comply with all applicable Federal Medicaid (Medi-Cal) laws, regulations, and guidelines, and all applicable state statutes and regulations;

2) Provide Specialty Mental Health Services, within scope of licensure, to all Clients who are referred by CONTRACTOR. To assist in referrals, providers shall, as a part of their application, indicate their specialties, which CONTRACTOR shall verify to the extent possible;

3) Appropriately refer Clients for other services when necessary;

4) Not refuse to provide services solely on the basis of age, sex, race, religion, physical or mental disability, or national origin;

5) Maintain a safe facility;

6) If applicable, store and dispense medications according to state and federal standards;

7) Maintain client records that meet state and federal standards; including but not limited to individualized treatment plans separate case notes. These shall be developed with Client and signed by Client.

8) Provide services at the rates established by CONTRACTOR, as agreed by ADMINISTRATOR;

9) Demonstrate positive outcomes as defined by CONTRACTOR;

10) Address the needs of Clients based on factors including age, language, culture, physical disability, psychiatric disability, and specified clinical interventions;

11) Meet QI, authorization, clinical, and administrative requirements of COUNTY and CONTRACTOR;

12) Work with Clients, their families, and other providers in a collaborative and supportive manner; and

13) Provide services in a managed care environment.

e. CONTRACTOR shall maintain a complete list of all Network Providers including name, license number, provider number(s), number of open clients, NPI number, specialty or specialties, language capabilities other than English, and geographic location and ethnicity. Any changes to the Network Provider list shall be submitted to ADMINISTRATOR on a monthly basis or as requested.

2. PROVIDER SELECTION AND CREDENTIALING – CONTRACTOR shall comply with Title 9, CCR, Section 1810.435 in the selection of providers and shall review its providers for continued compliance with standards at least once every three years, except as otherwise provided in the Contract.

a. CONTRACTOR shall include in its written provider selection P&P, a copy of which shall be provided to ADMINISTRATOR upon request, a provision that practitioners shall not be excluded solely because of the practitioner's type of license or certification.

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

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

3. NETWORK PROVIDER CREDENTIALING

a. CONTRACTOR and ADMINISTRATOR shall work together on credentialing Network Providers in accordance with State guidelines which include, but are not limited to, verifying the following information. Unless otherwise specified, primary source verification of information shall be required. Primary source verification means confirmation and evidence from the issuing source or designated monitoring entity of the requested information.

1) A current valid license to practice as an independent mental health practitioner;

2) A valid DEA certificate for physicians (primary source not required);

3) Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, and licensure of the mental health practitioner which is verified through license verification;

4) Board certification if the practitioner states that he/she is board certified on the application;

5) Work history (primary source not required);

6) Current, adequate malpractice insurance in accordance with the Indemnification and Insurance Paragraph of the Contract;

7) History of professional liability claims; and

8) Information from recognized monitoring organizations regarding the applicant's sanctions or limitations of licensure from:

a) State Board of Licensure or Certification and/or the National Practitioner Data Bank;

b) State Board of Medical Examiners, the Federation of State Medical Boards, or appropriate agency; and

c) OIG.

b. CONTRACTOR shall make every effort to ensure that the credentialing process does not exceed one hundred eighty (180) calendar days for any provider applying to become a Network Provider as evidenced by CONTRACTOR's receipt of a completed application, with the expectation that the average time for credentialing shall not exceed one hundred twenty (120) calendar days.

c. CONTRACTOR shall provide to COUNTY the names of providers denied participation in CONTRACTOR's Provider Network upon request.

4. OUT-OF-COUNTY PROVIDERS

a. CONTRACTOR may accept claims for services provided to a COUNTY Client by any out-of-county provider that has met the foundation criteria for the county in which services are provided.

b. CONTRACTOR shall provide names of its credentialed providers to other counties upon request.

5. RE-CREDENTIALING

a. CONTRACTOR shall update, verify and review all pertinent provider credentialing information and qualifications, and assess the provider's performance over the previous three (3) years.

b. CONTRACTOR shall identify and evaluate any changes in the provider's licensure, clinical privileges, training, experience, current competence, or health status that may affect the provider's ability to perform the services he or she is providing to members.

c. In order to determine whether to re-approve the provider's participation in CONTRACTOR's network, CONTRACTOR shall, in addition to updating credentialing information, examine the provider's clinical competence, examine QI, review patient complaints, and conduct site visits when appropriate, in accordance with CONTRACTOR's site audit policy, a copy of which shall be provided to ADMINISTRATOR upon request.

d. CONTRACTOR shall provide to COUNTY the names of providers denied participation in CONTRACTOR's Provider Network and the reason for the denial upon request.

6. PROVIDER APPLICATION REVIEW PROCESS

a. All credentialing and re-credentialing applications shall be reviewed by CONTRACTOR. Providers with identified adverse issues shall be asked to provide a written explanation prior to CONTRACTOR review. In addition, CONTRACTOR shall maintain P&Ps for altering the conditions of the practitioner's participation in the network based on issues of the

quality of care and service that may arise after completing the credentialing process. Such P&Ps shall be provided to ADMINISTRATOR, upon request. Decisions to alter or terminate a provider's participation in the network shall be made by CONTRACTOR. Providers with identified quality of care or service concerns shall be presented to the Peer Review Committee established by CONTRACTOR. Providers shall be advised in advance of the identified problems and shall be invited to respond in writing to the issues to go before the Peer Review Committee. The provider's response, along with any additional documentation supplied by CONTRACTOR, shall be reviewed by the Peer Review Committee. The Peer Review Committee may recommend that no action be taken, that the provider be issued a Corrective Action Plan, or that the provider be terminated from the network.

b. CONTRACTOR shall provide notice and a fair hearing to CONTRACTOR's Network Providers, as required under applicable state and federal law, or at the discretion of CONTRACTOR's Medical Director, in any case in which action is proposed to be taken by CONTRACTOR to restrict, suspend or terminate the Network Provider's ability to provide health care services to Clients for reasons relating to deficiencies in quality of care, professional competence, or professional conduct which affects or could adversely affect the health, safety or welfare of any Client and/or is reasonably likely to be detrimental to the delivery of quality care. If CONTRACTOR takes adverse action against a provider based on a quality-of-care issue, CONTRACTOR shall report as required by state and federal agencies and as required by the NPDB.

c. ADMINISTRATOR shall be notified of any providers required to submit a Corrective Action Plan, or terminated as the result of a quality-of-care issue, within fourteen (14) calendar days of such action. The quality-of-care issue shall also be summarized and included with the notification.

7. PROVIDER TRAINING

a. CONTRACTOR, in consultation with ADMINISTRATOR, shall train individual Network Providers to the model and delivery of Specialty Mental Health Services requested by COUNTY. Documentation, appropriate referral resource, and service linkage protocols shall be emphasized.

b. All Network Providers shall have access to a Provider Manual, developed by CONTRACTOR, at the commencement of their contract with CONTRACTOR. The Provider Manual shall be provided to ADMINISTRATOR, upon request.

c. CONTRACTOR shall update providers on operational and clinical requirements and to provide clarification on contractual issues. CONTRACTOR shall ensure communication and information is shared with providers via email, phone, scheduled meetings, and Peer to Peer discussions. Outreach and discussions will be based upon facility needs. ADMINISTRATOR

Quality Review information – currently in the form of QMS QR Tips – will be distributed to all ASO Network Providers.

d. CONTRACTOR shall conduct and/or sponsor in-service training for all of its Network Providers and any non-network providers as requested by ADMINISTRATOR. These trainings shall address both operational and clinical standards. For the purpose of coordinating trainings, CONTRACTOR shall provide a list of its scheduled trainings to ADMINISTRATOR.

8. CULTURAL AND LINGUISTIC CAPABILITY: CONTRACTOR shall make its best efforts to provide services pursuant to the Contract in a manner that is culturally and linguistically appropriate for the population(s) served. CONTRACTOR shall maintain documentation of such efforts which may include, but not be limited to: records of participation in COUNTY sponsored or other applicable training; recruitment and hiring P&Ps; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged.

a. CONTRACTOR shall recruit and retain culturally competent staff reflective of the populations receiving services including bilingual/bicultural professional staff. These staff shall have passed a proficiency exam that was approved by ADMINISTRATOR. CONTRACTOR shall utilize a language translation or interpreter or other service acceptable to ADMINISTRATOR.

b. CONTRACTOR shall actively solicit providers for its network to ensure that Client requests to use culture-specific providers are met. CONTRACTOR is not required to solicit only Medi-Cal providers for its network. Regular analysis of the Provider Network, including reports of Client satisfaction, shall be conducted in order to identify any network needs that might arise. In cases where a Client's request for a culture-specific provider cannot be met, CONTRACTOR shall conduct an immediate provider search to meet the Client's need and shall begin an expedited credentialing process in order to add the identified provider to the network. Qualified interpreters shall not be used to replace bilingual professionals, but may be utilized when no alternative is immediately available. A qualified interpreter shall be defined as a person who has not trained in mental health services, but has completed an appropriate course which covers terms and concepts associated with mental illness, psychotropic medications, and cultural beliefs and practices which may influence the Client's mental health.

D. CLAIMS PROCESSING AND ADJUDICATION – NETWORK PROVIDERS

1. CONTRACTOR shall maintain a rules-based and date-sensitive claims system to meet the needs of all standard Medi-Cal beneficiary claims.

2. CONTRACTOR shall establish a claims adjudication process which shall accept either paper or electronic claims including, but not limited to, verification that if the Client has a Share of Cost that the Share of Cost has been met.

3. CONTRACTOR shall maintain timelines in the claims process as follows:

a. Clean claims for services shall be requested to be submitted to CONTRACTOR by the Network Providers within thirty (30) calendar days of the date of services. CONTRACTOR shall follow all laws, rules, or regulations as described in the Licenses and Laws Paragraph of this Contract.

b. CONTRACTOR shall do its best to receive and process all Network Provider claims to avoid exceeding 365 days billing limit and avoiding Medi-Cal stale dated claims and reduced revenue receipts from the State.

c. CONTRACTOR should refer to and follow Services Paragraph of this Exhibit A.

E. MEDI-CAL CLAIMS PROCESSING AND REVIEW

1. CONTRACTOR shall maintain a thirty (30) calendar day or less turnaround on clean claims. Clean claims shall be those that require no additional information (such as provider identification, diagnosis, accurate modifiers, and/or CPT codes) and which can be processed completely upon initial entry.

a. When pending a claim for missing data, the Network Provider shall receive notification from CONTRACTOR within fourteen (14) calendar days from the date of receipt. This notification shall include what is needed to continue processing the claim.

b. CONTRACTOR shall request that the information be returned within fourteen (14) calendar days.

c. CONTRACTOR shall actively adjudicate or resolve any of CONTRACTOR's denied claims of Network Providers to ensure timely submission of all Mental Health Claims within twelve (12) months of the Date of Service.

2. CONTRACTOR shall:

a. Provide adequately trained claims processing and clerical staff, and suitable equipment.

b. Review each completed claim to determine that the services rendered are within the Medi-Cal scope of service, and that applicable prior approvals have been obtained.

c. Share of Cost – CONTRACTOR shall require that all Network Providers attempt to collect the Share of Cost from Clients and that reimbursement of claims shall be reduced by the Clients' Share of Cost.

d. CONTRACTOR shall have access to the Medi-Cal Eligibility Website to determine client eligibility and any Share of Cost remaining for the date of service. ADMINISTRATOR will provide technical assistance and support as needed to identify client fall-out from eligibility file as it relates to claims payment.

e. CONTRACTOR shall have access to inpatient Treatment Authorization Request (TAR) data and IMD information as they relate to paying inpatient and IMD physician claims. These lists will be provided by ADMINISTRATOR. CONTRACTOR will also utilize CONTRACTOR's own Concurrent Review Authorization Data to adjudicate physician claims along with TAR data.

f. CONTRACTOR shall ensure that the Network Providers notify the Client of his/her Share of Cost obligation. The Client shall be made to understand that when the Share of Cost obligation is met, Medi-Cal will cover the remainder of the unit cost.

g. For Clients with a Share of Cost who have the ability to meet their Share of Cost obligation, CONTRACTOR shall maintain authorization procedures that include ongoing review of a Client's Share of Cost status. CONTRACTOR shall make all reasonable efforts to ensure that all authorized services are eligible for Medi-Cal reimbursement.

h. CONTRACTOR shall ensure that a Client with a Share of Cost was eligible for Medi-Cal on the date of service during the adjudication process of the Network Provider's claim.

i. The spend-down of Share of Cost is the amount remaining for the month of the date of service, or the amount of the service, whichever is less.

j. CONTRACTOR shall maintain procedures regarding the referral of Clients who:

1.) Are unable to pay their Share of Cost and for whom the denial of mental health services based on inability to pay Share of Cost would result in a significant functional impairment, or

2.) CONTRACTOR is unable to determine if they have met their Share of Cost for other Medi-Cal services received and for whom the denial of Mental Health Services based on inability to pay Share of Cost would result in a significant functional impairment.

k. The Network Provider shall send in a claim form, reflecting the gross amount, Share of Cost amount (if applicable) and the balance due after the Share of Cost has been met.

l. If the Network Provider's claim is sent with a balance due, CONTRACTOR shall verify Share of Cost remaining to avoid double payment, as well as verify if payment is correct due to Share of Cost reporting lag.

3. Other Health Coverage – CONTRACTOR shall direct Clients with Other Health Coverage that includes behavioral health coverage to seek services through Network Providers who take the Other Health Coverage in which they are enrolled.

a. CONTRACTOR shall direct Clients who obtain Other Health Coverage that includes behavioral health coverage, and who have been receiving services by an ASO Network Provider to seek services as soon as possible through other Providers who take Other Health Coverage in which they have become enrolled.

b. CONTRACTOR shall direct Clients with Other Health Coverage that does not include behavioral health coverage to seek services through COUNTY for a level of care assessment and further treatment if medically necessary.

c. CONTRACTOR shall direct Clients who obtain Other Health Coverage that does not include behavioral health coverage after they have been seeing an ASO Network Provider to seek services as soon as possible through COUNTY for a level of care assessment and further treatment if medically necessary.

d. This is subject to change if the DHCS rules change regarding accepting claims for Other Health Coverage that does not include behavioral health coverage.

e. CONTRACTOR shall direct inpatient providers who submit claims for Clients with Medicare to bill fee-for-service Medi-Cal directly as described in the Medi-Cal manual.

f. CONTRACTOR shall direct inpatient providers who submit claims for Clients with Other Health Coverage other than Medicare to also send proof of denial or partial payment with the CMS1500 to CONTRACTOR who shall pay remainder up to what would have been paid if only Medi- Cal eligible.

4. Payment/Claim Resolution

a. CONTRACTOR shall facilitate the resolution of problems concerning payment and any billing documentation (if necessary) with Network Providers.

b. In the event a payment dispute arises between CONTRACTOR and a Network Provider, CONTRACTOR shall make every attempt to resolve such disputes up to and including the use of a formal provider appeal process. All CONTRACTOR actions shall be undertaken while keeping the rights of the Client the foremost priority.

c. If a Network Provider disputes the denial of a submitted claim or the amount of payment, he/she may contact CONTRACTOR's Claims Department. The Claims Department shall be able to review the adjudication process with the Network Provider and give a more detailed explanation of a denied encounter unit or a reduced payment. If, in the course of such contact, CONTRACTOR is able to determine that an error was made on the part of CONTRACTOR, a re-adjudication of the claim shall be made so that the proper payment amount may be remitted.

d. If, for any reason, CONTRACTOR is unable to resolve the problem to the full satisfaction of the Network Provider, CONTRACTOR shall offer to facilitate the formal second level PDR review. CONTRACTOR's appeal process shall include review by CONTRACTOR's Account Executive, CONTRACTOR's AVP of Operations, and CONTRACTOR's VP of Operations. If, after the third level appeal, the provider still is not satisfied, he/she will be referred to COUNTY or State Medi-Cal appeals process.

e. All appeals processes shall be communicated to Network Providers via the distribution of CONTRACTOR's provider manual at the time of contracting.

f. CONTRACTOR shall be responsible to all Network Providers for funds paid, in any form, for non-reimbursable services, for services to persons who are not Medi-Cal Beneficiaries, or for payment to any provider or other entity not entitled to such payment. CONTRACTOR shall reimburse the ASO Account for any such payments. CONTRACTOR may pursue reimbursement from affected providers, as appropriate.

F. MEDI-CAL CLAIMS PROCESSING AND REVIEW - CONTRACTOR shall provide COUNTY, at a minimum, a bi-monthly Medi-Cal 837 claiming file:

1. CONTRACTOR shall provide 837 files by fiscal year:

a. Current fiscal years in single file – Files should not exceed 5,000 claims;

b. All Prior fiscal years in single file – Flies should not exceed 5,000 claims;

2. With the exception of claims for IMD, this file shall contain a matching Medi-Cal claim for each Medi-Cal claim that was adjudicated by CONTRACTOR to the Network Provider.

3. CONTRACTOR shall also:

a. Ensure that all billing activity is accurate, maintained, controlled and exchanged as necessary in compliance with all current Federal requirements, as well as State regulatory requirements as set forth by DHCS;

b. Ensure that billing staff has a thorough knowledge and understanding of SDMC billing on an ongoing basis. It is the responsibility of CONTRACTOR to maintain this knowledge and train staff when changes in staffing and/or regulations occur. ADMINISTRATOR is available to be a consultant on fine points or details; but will not train CONTRACTOR's new staff.

c. Ensure compliance on an ongoing basis with emerging and future Federal and State regulatory requirements within established deadlines;

d. Work cooperatively with and shall notify ADMINISTRATOR during any system/application changes or enhancements to ensure continuity of compliant operations;

e. Ensure Federal HIPAA compliance;

f. Have staff and system capability to compile and electronically transmit Medi-Cal 837 claim files (as indicated in F. above) to ADMINISTRATOR (OC HCA - BHS- approved and system) for submission to and adjudication by the State of California;

g. Have ability to receive electronic transmissions of Medi-Cal 835 adjudicated claims files back from ADMINISTRATOR, if necessary, as received by the State of California;

h. Resolve any issues with errors in claim submissions within the established timeframes, and perform re-submissions as necessary;

i. Review all claims to see that the claims are billed within the twelve (12) months from DOS requirement. Any stale dated claims (those over twelve (12) months) shall be the responsibility of CONTRACTOR and not billed to ADMINISTRATOR. Any stale dated claims that may have been previously reported to and paid by ADMINISTRATOR shall be reimbursed to ADMINISTRATOR as indicated in the Services Paragraph of this Exhibit A to the Contract.

j. Report all stale dated costs to ADMINISTRATOR. These costs shall be reported on the monthly Expenditure and Revenue Report; as requested by ADMINISTRATOR.

k. CONTRACTOR shall maintain a complete list of all provider claims including name, license number, provider number(s), billing date, amount, and claim status to submit to ADMINISTRATOR for review on a monthly basis

l. Conduct weekly reviews and audits to see that claims submissions by Outpatient and Inpatient Providers and payments for approved claims and denied claims were adjudicated accurately. If the review/audit reveals that money is payable from one Party to the other, that is, reimbursement by CONTRACTOR to COUNTY, or payment of sums due from COUNTY to CONTRACTOR, said funds shall be due and payable from one Party to the other within sixty (60) calendar days of receipt of the review/audit results.

1) If claims to be reimbursed are within the current fiscal period, the claims shall be settled through the monthly Expense and Revenue Report and payment process.

2) If claims to be reimbursed are not within the current fiscal period, CONTRACTOR shall reimburse COUNTY.

3) If reimbursement is due from CONTRACTOR to COUNTY, and such reimbursement is not received within said sixty (60) calendar days, COUNTY may, in addition to any other remedies provided by law, reduce any amount owed CONTRACTOR by an amount not to exceed the reimbursement due COUNTY.

4. CONTRACTOR shall establish an ongoing primary technical contact or project manager with whom issues can be discussed and resolved.

5. CONTRACTOR shall not conduct any proselytizing activities, regardless of funding sources, with respect to any individual(s) who have been referred to CONTRACTOR by COUNTY under the terms of the Contract. Further, CONTRACTOR agrees that the funds provided hereunder shall not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

6. CONTRACTOR shall provide effective Administrative management of the budget, staffing, recording, and reporting portion of the Contract with COUNTY. If administrative responsibilities are delegated to subcontractors, CONTRACTOR must ensure that any subcontractor(s) possesses the qualifications and capacity to perform all delegated responsibilities, including but not limited to the following.

a. Designate the responsible position(s) in your organization for managing the funds allocated to this program;

b. Maximize the use of the allocated funds;

c. Ensure timely and accurate reporting of monthly expenditures;

d. Maintain appropriate staffing levels;

e. Request budget and/or staffing modifications to the Contract;

f. Effectively communicate and monitor the program for its success;

g. Track and report expenditures electronically;

h. Maintain electronic and telephone communication between key staff and the Contract and Program Administrators; and

i. Act quickly to identify and solve problems.

G. BENEFICIARY ACCESS LINE

1. CONTRACTOR shall staff and operate a twenty-four (24) hour-seven (7) days a week toll free Access Line which is a primary portal of entry for providers and Orange County Medi-Cal Beneficiaries and their families for Substance Use Disorder and Mental Health Services. This line may not be a taped recording and must have a live operator at all times.

2. CONTRACTOR shall provide brief screening to determine services requested and level of care for referral to an appropriate provider to receive a full assessment.

3. CONTRACTOR shall utilize a script developed by ADMINISTRATOR for answering Access Line requests for services.

4. CONTRACTOR's Access Line shall ensure that services are available in all threshold languages. For enrollees who may require language translation, CONTRACTOR shall utilize a language interpreter service or other service acceptable to ADMINISTRATOR. The California Relay Service may be used for hearing-impaired members.

H. MENTAL HEALTH SERVICES

1. SCREENING

a. CONTRACTOR shall provide the Client with a very brief screening to first determine if the Client is seeking mental health services followed by verification of Medi-Cal eligibility. CONTRACTOR shall comply with any requirements for mental health screenings as set by DHCS and directed by ADMINISTRATOR.

b. If the caller is not verified to be a Medi-Cal Beneficiary, CONTRACTOR shall complete brief screening and refer the individual to the local COUNTY Medi-Cal Office for potential enrollment and provide community resources for treatment.

c. At no time, shall a caller be offered a call back to conduct screening and complete linkage to services unless stated in Telephone Access Log as a caller's request.

d. CONTRACTOR shall screen Clients who are requesting services not provided by CONTRACTOR and identify and provide resources.

2. CASE MANAGEMENT SERVICES - Whenever clinically necessary, CONTRACTOR's case managers shall assist and support Clients as part of care coordination services. Clinicians shall link Clients with complex or co-morbid conditions to appropriate care, focus on the integration of mental health and primary care, and help Clients connect to their PCPs or collaborate with their health plan to assure timely services are received.

3. TIMELY ACCESS TO SERVICES – When a call is received through the Access Line, CONTRACTOR shall determine and document in Access Log if the request for services is emergent, urgent, or routine.

a. If the caller's needs are indicated as requiring emergent or urgent care, CONTRACTOR shall make a referral to COUNTY's CAT or COUNTY Mental Health Outpatient Clinic without delay to prevent further decompensation or compromise of the member's condition. CONTRACTOR shall at no time refer callers to inpatient care and must follow COUNTY criteria for inpatient assessment.

1) Emergent services shall be indicated when the Client has a psychiatric condition that meets COUNTY's criteria for acute psychiatric hospitalization and cannot be treated at a lower level of care. These criteria include the Client being a danger to himself/herself or others or an immediate inability of the Client to provide for, or utilize food, shelter or clothing as a result of a mental disorder. These calls must be provided warm-linkage to the COUNTY OC Links/Crisis Assessment Team for further evaluation and treatment.

2) Urgent services shall be indicated when a situation experienced by a Client that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.Clients in need of urgent services shall receive timely mental health intervention that shall be appropriate to the severity of the condition. Linkage for these services must be within forty-eight (48) hours.

3) CONTRACTOR must obtain confirmation that any caller assessed as requiring emergent or urgent care has been appropriately connected to COUNTY or emergency services. If the Client did not show up to the appointed session/evaluation, CONTRACTOR shall contact the Client to further facilitate services.

4) Appointment standards regarding emergent and urgent care shall be communicated to Network Providers as part of the Network Provider handbook and shall be incorporated in their Network Provider contractual agreement with CONTRACTOR.

b. If the caller's needs are indicated as requiring routine care, CONTRACTOR shall make a referral to COUNTY for an appointment to be offered within ten (10) business days of the referral. Routine services shall be indicated when a Client's mental health needs are not

urgent, but for whom mental health services of some type can improve functioning and/or reduce symptoms, or for whom mental health services are necessary to maintain his or her highest level of functioning.

c. CONTRACTOR's Access Line clinicians shall be available to briefly screen and triage all of the Client's mental health needs. All of CONTRACTOR's Access Line clinicians providing brief screening services shall be licensed by the State of California, Board of Behavioral Sciences. Access Line clinicians shall be trained to identify signs of distress in callers.

d. Clients requesting mental health services shall not be denied services solely based upon a telephone clinical screening. Should it not be possible to determine a Client's needs, during the brief telephone clinical screening, CONTRACTOR shall take further steps to ensure Clients are referred to the most appropriate level of care by referring the Client for a face-to-face assessment by COUNTY provider.

1) A referral for a face-to-face assessment shall be culturally appropriate.

a) CONTRACTOR shall require that testing be provided only by licensed clinical psychologists. CONTRACTOR shall make referrals for testing to the Medi-Cal Managed Care Plan (MCP) or Mental Health Plan (MHP).

e. Access Line clinicians shall be evaluated at least once annually by CONTRACTOR to ensure consistency and appropriateness of referrals. CONTRACTOR shall make findings available to ADMINISTRATOR.

1) CONTRACTOR's Access Line clinicians shall be periodically evaluated by CONTRACTOR through routine audits and formal reliability studies to ensure consistency in decisions related to medical necessity and clinical impressions.

2) A randomly selected sample of member files shall be audited by CONTRACTOR at least quarterly to evaluate Access Line clinician decision compliance with decision-making criteria.

4. SCREENING and ASSESSMENT – CONTRACTOR shall comply with any requirements for mental health screenings as set by DHCS Information Notices and directed by ADMINISTRATOR. This includes complying with DHCS information notices and CalAIM guidance on the determinants for level of care referrals and linkage.

a. Out of County Services - CONTRACTOR shall be responsible for processing and paying claims for services provided to COUNTY Clients who meet medical necessity for treatment and may require services while out of Orange County as a result of urgent need or placement by COUNTY care coordinators and/or Social Services staff.

1) CONTRACTOR shall comply in good faith with all Medi-Cal rules and regulations applicable to the provision of Specialty Mental Health Services for Medi-Cal Beneficiaries who are minors and who reside out-of-home and out of Orange County.

2) COUNTY shall cooperate with CONTRACTOR in connection with providing authorization for services to Clients who are deemed by the appropriate state or federal authorities to be COUNTY's Medi-Cal responsibility. COUNTY may retain responsibility for providing services for any minor placed out of Orange County at COUNTY's discretion, after notification to CONTRACTOR, at any point in the treatment.

b. Other Need for Services – Clients shall be referred to their MCP or PCP for treatment, if Client's face-to-face assessment determines that the mental health need would be responsive to physical health care-based treatment. Mental disorders that result from a general medical condition shall be excluded from the medical necessity criteria for treatment, provided a NOABD, if applicable and, beyond assessment, are not the responsibility of COUNTY or CONTRACTOR.

5. AUTHORIZATION OF SERVICES

a. Inpatient and IMD Services – Acute Inpatient Hospital and IMD Clients shall meet medical necessity for treatment per DHCS Concurrent Review requirements. CONTRACTOR shall be responsible for reimbursing attending psychiatrists at both acute inpatient hospitals and IMDs. Claims for services for these Clients shall be processed in accordance with the following:

1) Acute Psychiatric Hospitals and IMDs – Attending psychiatrists shall be reimbursed by FFS rates set by CONTRACTOR and agreed to by COUNTY.

2) CONTRACTOR shall not reimburse attending physicians for services at IMDs designated as COUNTY contracted as services are inclusive in the facility charges.

3) CONTRACTOR must ensure that no reimbursement of IMD services is made for Clients 22 – 64 years of age.

4) CONTRACTOR must ensure that it does not reimburse for more than one (1) professional service per day without prior authorization.

5) CONTRACTOR must ensure that psychiatrist's claims are appropriately adjudicated, and services rendered support billed CPT codes.

b. Out of County Treatment Authorization

1) CONTRACTOR may accept claims for authorized outpatient Specialty Mental Health Services by any out of County provider that has completed a single case agreement with CONTRACTOR.

2) CONTRACTOR shall monitor claims payments to non-contracted out of County providers for outpatient Specialty Mental Health Services billed to CONTRACTOR. Any out of County provider meeting this criterion shall be advised in writing by CONTRACTOR that the cumulative claims exceeding $1,000 shall be denied unless provider becomes a Network Provider in CONTRACTOR's network. CONTRACTOR shall also advise Network Providers

that they must obtain authorization from CONTRACTOR for ongoing services. These services shall be authorized following the in-county benefit guidelines.

3) Children and adolescent Clients shall be allowed up to fifteen (15) visits for medication management; one (1) assessment visit, one (1) hour in duration; and fourteen (14) follow-up visits, fifteen (15) minutes in duration.

4) CONTRACTOR shall authorize up to twenty-six (26) therapy visits over a six (6) month period. The type of therapy; Individual, Group, or Family therapy; shall be at the discretion of the Network Provider.

c. Eating Disorder Residential, Intensive Day and Outpatient Services – Eating Disorder Clients shall meet medical necessity for treatment per DHCS. CONTRACTOR shall be responsible for reimbursing provider contracted services at Residential, Intensive Day and Outpatient levels of care. Claims for services for these Clients shall be processed in accordance with the following:

1) Eating Disorder Programs – Provider contracted services shall be reimbursed by FFS rates set by CONTRACTOR and agreed to by COUNTY.

2) CONTRACTOR must ensure that it does not reimburse for more than one (1) professional service per day of any type without prior authorization.

3) CONTRACTOR must ensure that eating disorder service claims are appropriately adjudicated, and services rendered support billed CPT codes.

d. Outpatient Specialty Mental Health Services – If a Client is identified through CONTRACTOR's automated UM monitoring report as continuing or exceeding treatment allowed in Services Paragraph of this Exhibit A to the Contract, an Access Line clinician will conduct additional review and/or assessment via Continued Care Review (CCR) to determine medical necessity and level of care remain appropriate to the Clients' needs and the planned treatment will potentially improve Clients' condition and level of functioning.

1) The CCR involves consultation with Network Providers and shall include, at a minimum, a statement of presenting problems including diagnosis, justification for extended services, a brief treatment plan including the number of additional requested services to resolve the problem, treatment goals, as well as information relevant to the specific diagnosis, mental status, symptomatology, functional impairment, and a description of linkages to other community resources and support groups. The CCR also may involve rescreening the Client which, if applicable, shall include, at a minimum, determination of appropriate level of care, functional limitations and treatment barriers, service verification, identification of unmet resource needs and self-report measure of treatment effectiveness and satisfaction.

2) If the Access Line clinician determines the Client no longer meets Specialty Mental Health criteria, a transition of care to the MCP is facilitated by CONTRACTOR in coordination with the MCP.

3) If the Access Line clinician determines the Client may require COUNTY level of care and may be better served by COUNTY, the Client may be referred and linked to COUNTY for further assessment. If COUNTY assessment determines COUNTY level of care is not appropriate, COUNTY reserves the right to refer Client to their Managed Care Plan (MCP) for services.

4) With approval from ADMINISTRATOR, the utilization process can be modified and/or replaced by other similar systems that authorize more hours of treatment than initially allowed to a Client provided that justification includes utilizing the minimum criteria detailed in the Services Paragraph of this Exhibit A to the Contract.

5) Access Line clinicians shall utilize Medical Necessity criteria and as needed, consultations with designated COUNTY staff to guide the screening for medical necessity and appropriateness of mental health services.

e. Outpatient Psychiatric Medication and Adult Psychotherapy Services

1) Clients shall be allowed up to twelve (12) visits for psychiatry and up to twenty-six (26) visits for routine psychotherapy within the initial six (6) months. Additional hours of service will require CCR by CONTRACTOR with oversight by the Medical Director.

2) CONTRACTOR, by CCR, can allow up to twelve (12) visits for psychiatry and up to twenty-six (26) visits for routine psychotherapy within the subsequent six (6) months before additional review is required. CONTRACTOR shall develop appropriate service utilization criteria."

6. COORDINATION WITH PHYSICAL HEALTH CARE – CONTRACTOR shall address the following issues in coordinating mental health and physical health care services with the managed care plan:

a. Timely coordination and referral.

b. Timely exchange of information.

c. Education of both Clients and Network Providers regarding system coordination.

d. Coordination of medications and laboratory services as they relate to the mental health and physical needs of the Client.

1) A part of CONTRACTOR's CCR process shall include collecting and evaluating the Client's medication regimen.

2) If CONTRACTOR's Access Line clinicians discover potential coordination of medication concerns, telephone calls shall be placed to the Network Provider and managed care plan to ensure appropriate coordination of care.

e. Defining responsibility/roles of case management/care coordination services.

1) Whenever clinically necessary, CONTRACTOR's clinicians shall work with the local managed care plan(s) case management departments and membership liaison staff to coordinate necessary services.

2) CONTRACTOR shall also have access to IRIS to assist in identifying which Clients are accessing the traditional Short-Doyle delivery system and shall coordinate client care with COUNTY mental health staff at corresponding program(s) where Client is receiving services.

3) Specialty Network Provider consultation shall be provided to the Client's MCP or PCP. Upon appropriate Client consent, Network Providers shall coordinate with the MCP or PCP regarding a patient concern. With proper Client consent, CONTRACTOR shall release the information from the Network Provider to the MCP or PCP to facilitate care coordination.

4) CONTRACTOR shall require its Network Providers to follow community standards of good clinical practice, provide informed consent and clarification to Clients about treatments that may impact their service delivery, and to update the MCP or PCP regarding the progress of the treatment.

7. DENIALS, REDUCTIONS, OR TERMINATION OF MENTAL HEALTH SERVICES

a. All reductions in benefits and/or denials of treatment authorization shall be reviewed by CONTRACTOR.

b. In the event that CONTRACTOR reduces benefits or denies further treatment entirely, both the Network Provider and Client shall be notified by CONTRACTOR in writing by sending a NOABD form.

1) If services are denied, CONTRACTOR shall send an NOABD form.

2) If services, as requested by the Network Provider, are terminated, reduced, or changed and authorized by CONTRACTOR, CONTRACTOR shall send a NOABD form.

3) Quarterly, CONTRACTOR shall submit to COUNTY, a report listing all NOABDs issued by type.

4) CONTRACTOR shall provide detailed information substantiating the issuance of a NOABD, upon request of ADMINISTRATOR.

c. COUNTY shall supply CONTRACTOR with DHCS approved templates for Notice of Grievance Resolution (NGR), Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolutions (NAR). All NOABD forms include instructions regarding second opinion and appeals/expedited appeals processes. All notices must include a patient's rights attachment, non-discrimination notice and language assistance taglines.

1) A Client may request a second opinion and appeal within sixty (60) calendar days from the date of the NOABD. CONTRACTOR is responsible for second opinions and appeals for NOABDs issued by CONTRACTOR. CONTRACTOR shall respond to Client appeals with a written acknowledgement, postmarked within five (5) calendar days of the appeal request.

2) A Network Provider or Client may request an expedited appeal review in the event that treatment is ongoing.

3) CONTRACTOR shall follow Federal regulations for standard and expedited resolution timeframes. Should CONTRACTOR fail to respond to the appeal or expedited appeal within the mandated timelines, CONTRACTOR shall send the Client a grievance and appeal NOABD form.

4) CONTRACTOR shall send a formal NAR letter informing Clients of the appeal outcome and provide a copy to the provider and COUNTY.

I. UTILIZATION MANAGEMENT - CONCURRENT REVIEW OF INPATIENT HOSPITAL SERVICES

1. In accordance with the Mental Health Plan (MHP) Agreement with the Department of Health Care Services (DHCS) and federal Medicaid Managed Care and Parity Final Rule 42 CFR, Part 438, 440, 456, and 457 (Code of Federal Regulations), WIC 14197, 14705(a)(3), California Code of Regulations (CCR), Title 9, Chapter 11, Sections 1810.216, 1810.440(b), 1820.205, 220-225, 230, 245, 18220.205(a), 1830.220-225, HSC 1367.01(h)(3) & 1371.4(a), CONTRACTOR agrees to render psychiatric inpatient hospital Initial and Continuing Stay Concurrent Review services, also referred to as utilization management (UM) services, to eligible Clients for Specialty Mental Health Services (SMHS) as set forth in this Exhibit A of the Contract in accordance with Mental Health Substance Use Disorder (MHSUDS) Information Notice (IN) 19-026, DHCS Information Notice 22-017, and any subsequent Information Notices applicable to Concurrent Review of Inpatient Services. COUNTY agrees to pay CONTRACTOR for such services rendered in accordance with the terms and under the express conditions of this Contract.

a. Service Delivery

1) CONTRACTOR's UM services shall evaluate and authorize inpatient psychiatric hospital admissions and continued stay days based on Specialty Mental Health Services (SMHS) medical necessity criteria, and consistent with current clinical practice guidelines, principles and process. CONTRACTOR shall authorize service appropriateness and efficiency of services provided to Medi-Cal Beneficiaries, and those Orange County residents COUNTY designates Mental Health Inpatient Services Youth and Adults (also known as MHIS or uninsured clients), prospectively through initial and concurrent authorization procedures. CONTRACTOR may place appropriate limits on a service based on medical necessity, or for the

purpose of utilization management, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve their purpose and that services for Clients with ongoing or chronic conditions are authorized in a manner that reflects the Client's ongoing need for such services and supports.

2) CONTRACTOR shall maintain telephonic and electronic methods for providers to submit notification of admission twenty-four (24) hours per day, seven (7 days) per week (24/7), so that inpatient hospital providers are able to make admission notifications and request authorization for inpatient acute psychiatric hospital services.

3) CONTRACTOR may not arbitrarily deny or reduce the amount, duration, or scope of the required service solely because of diagnosis, type of illness or condition of the Client (CCR Title 9, 1810; 42 Code of Federal Regulations (CFR) 438.210, 438.330, 438.608; 438.910).

4) CONTRACTOR shall provide written notification to COUNTY regarding authorization decisions in accordance with the established timeframes based on medical necessity via Daily Census Report and daily Authorization List.

5) CONTRACTOR hereby represents and warrants that it operates a utilization management program based on the National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services' (CMS) standards for Medicaid/Medi-Cal; provided, however, that it makes no representation or warranty that it is accredited by NCQA. CONTRACTOR's UM program shall set quality standards based on the Healthcare Effectiveness Data and Information Set (HEDIS) and other related performance measures.

b. Utilization Management Service

1) COUNTY does not require prior authorization for an emergency admission for psychiatric inpatient hospital services or to a psychiatric health facility, whether the admission is voluntary or involuntary, and the Client, is a current danger to self or others, due to a mental health disorder and/or a severe substance use disorder is or immediately unable to provide for, or utilize, food, shelter, or clothing. (CCR Title 9, 1820, 1830 sections).

2) After the date of admission, CONTRACTOR shall review requests from hospitals for authorization of continued stay services for the Client subject to concurrent review by CONTRACTOR in accordance with DHCS Information notices and regulations listed above.

3) As part of Concurrent Review/UM activities, CONTRACTOR shall:

a) Maintain an Information Technology (IT) system configuration that includes - list of Medi-Cal covered diagnoses for inpatient mental health services; secure protocol for electronic communication between CONTRACTOR and COUNTY, covered county responsible and Medi-Cal client eligibility, authorization, and inpatient acute mental health provider information.

b) Maintain Phone system and encrypted email inbox set up with dedicated telephone number and phone tree for network provider calls on behalf of COUNTY.

c) Provide mutually agreed upon reports as defined in this Exhibit A. However, CONTRACTOR shall provide to COUNTY any additional reports COUNTY requires to comply with applicable law or government agency instruction. COUNTY shall cooperate with collecting and providing any data needed to perform the services and supply reports required under this section.

d) Maintain and update (as applicable) written guidelines and workflows outlining CONTRACTOR's compliance with DHCS requirements for Concurrent Review.

e) Develop eligibility verification processes for Orange County responsible Clients, including Medi-Cal and uninsured Orange County youth and adults. CONTRACTOR shall work with the HCA on the MEDS file to verify Medi-Cal status of all concurrent reviews. CONTRACTOR shall have a process and work with Clients assigned facilities to confirm eligibility.

f) Develop and share policies and procedures in compliance with the Final rule and DHCS regulatory and MHP Contract requirements to address the following areas including, but not limited to:

i. Medical necessity criteria, as defined in CCR Title 9, section 1820.205 for initial and continued stay services and 1820.220 for administrative day services;

ii. Clinical coverage and access to utilization management staff 24-hour access to utilization review staff;

iii. Timeliness of authorization decisions and notification;

iv. Discharge planning;

v. Clinical documentation;

vi. Evaluation of utilization management services, including but not limited to, interrater reliability and objectivity in clinical decision making;

vii. Notification requirements and content of authorization and need for adverse benefit determination notices (COUNTY approved NOABDs);

viii. Required UM staffing and scope of practice, including licensed mental health professional licensure, verified credentialing, sanction/exclusion monitoring and certification of clinical staff; and

ix. UM staffing compensation is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Client.

g) Purchase equipment and set up new information technology equipment for new staff.

h) Train UM staff on new workflows, medical necessity criteria and new required system.

i) Monitor Concurrent Review activities performed by UM staff to ensure compliance to the established workflows and documentation requirements preapproved by COUNTY and set forth in this Exhibit A.

j) Facility notification of updates to the Concurrent Review process.

c. Utilization Management Program Scope and Design

1) CONTRACTOR's Clinical UM Program shall assign a designated point of contact with COUNTY. This individual shall be responsible for the performance of the joint CONTRACTOR team designated for COUNTY account and shall be located in CONTRACTOR's Service Center. The UM team shall include designated licensed practitioners of the healing arts, UM clinicians, including UM physicians, intake coordinators and shared reporting and oversight resources, to support the Contract.

2) CONTRACTOR team shall be responsible for the following:

a) COUNTY specific admission notification phone number and secure electronic submission process available to providers and COUNTY 24/7 for initial and continuing stay authorization requests. COUNTY will access CONTRACTOR's notification services upon receiving direct contact from a facility regarding notification and authorization request.

b) Daily intake of an admissions census showing current admissions at acute psychiatric inpatient hospitals. CONTRACTOR shall update COUNTY of all completed admissions through a COUNTY pre-approved authorization extract via daily email delivery to COUNTY email address determined by COUNTY.

c) Client eligibility verification by utilizing via an eligibility file and/or face sheet provided by COUNTY. Eligibility verification shall include adult and children who have County 30 Medi-Cal or County Responsible benefits.

d) Timely review and approval, denial or modification of requests for authorization of inpatient mental health services. CONTRACTOR shall not deny authorization of emergency placements.

e) Use written Concurrent Review decision-making criteria, pre-approved by COUNTY, that are objective and based on inpatient acute psychiatric hospital/PHF medical necessity as defined in CCR Title 9 Section 1820.205 for initial and continuing stay services and 1820.220 for administrative day services.

f) Review clinical documentation, when necessary, sufficient to determine that medical necessity criteria are met for acute days and administrative day criteria are met for administrative day authorized by CONTRACTOR.

g) Formal and informal case collaboration with COUNTY or Inpatient

facility staff, including physician peer review for resolving disputed requests for authorization.

h) Provide peer to peer consultation from board certified physicians to facilities as clinically appropriate for each Client.

i) Ensure that medical necessity adverse benefit decisions, based on medical necessity criteria are reviewed and approved by a physician as set forth in CCR Title 9 section 1820.220, prior to providing COUNTY with written reasons for generating a Notice of Adverse Benefit Determination (NOABD) letter.

j) Coordination and discharge planning with facility and COUNTY staff as appropriate, including but not limited to:

i. CONTRACTOR to notify COUNTY designated contacts via email of Client's planned discharge date from inpatient unit no less than twenty-four (24) hours prior to discharge/final day authorized, or the next business day if notified outside of the work week, or as soon as CONTRACTOR is made aware of a discharge if not informed sooner than twenty-four (24) hours.

ii. CONTRACTOR to obtain and document discharge plan, including aftercare appointment information, during Concurrent Review process, for all clients, including non-Orange County SMHS discharges or Out-of-County aftercare services.

iii. CONTRACTOR to notify inpatient hospital unit social worker staff/UM representative that they are to contact COUNTY OPEN ACCESS clinical staff to coordinate discharge plan for SMHS by calling number provided by ADMINISTRATOR prior to discharge.

k) Routine Activity Report deliveries, including but not limited to facility type, average length of stay, recidivism, and Client demographic information.

i. COUNTY will continue to manage all facility and provider contracts. The above activities will be completed for acute mental health inpatient care and any UM review services mutually agreed upon by CONTRACTOR and ADMINISTRATOR.

ii. COUNTY will assign a designated point of contact with CONTRACTOR.

iii. CONTRACTOR shall respond to up to two (2) quarterly clinical audits from COUNTY per fiscal year, and shall participate in clinical audits of COUNTY by state or federal authorities as needed, or as requested by ADMINISTRATOR. Notwithstanding audits initiated by state or federal authorities, COUNTY shall give CONTRACTOR no less than thirty (30) business days' notice to respond to a clinical audit request.

d. Workflow Overview

1) CONTRACTOR shall implement effective workflows for clinical review based on established policies and practices.

2) Initial Admission Authorizations:

a) CONTRACTOR shall verify COUNTY eligibility upon an individual admission.

b) For eligible admissions, CONTRACTOR support staff shall set up a member file in CONTRACTOR care management system that includes member demographics, eligibility, and other pertinent details. CONTRACTOR support staff shall conduct screening and enter notes into CONTRACTOR care management system. Any case requiring clinical review by a clinician shall be transferred to an UM Coordinator.

3) UM Reviews: Provide Concurrent Review services for Clients placed in inpatient psychiatric facilities as directed by COUNTY, including but not limited to, the following:

a) Provide timely review and approval, denial or modification of requests for authorization of inpatient mental health services.

b) Use Concurrent Review decision-making criteria, pre-approved by COUNTY, that are objective and based on medical necessity as defined in CCR Title 9 Section 1820.205 for initial and continuing stay services and 1820.220 for administrative day services.

c) Inform Clients in writing how they can obtain the Concurrent Review criteria and make the criteria available to Clients upon request.

d) Provide Inpatient Facilities Initial and Concurrent Review Authorization letters outlining authorized acute and administrative days.

e) Once daily, on business days, send census to COUNTY Utilization Review team email. To be determined by COUNTY, at minimum, the following information for all Clients currently in inpatient psychiatric placement shall be provided:

i. Client name Date of Birth, and Alternate ID;

ii. Diagnoses;

iii. Placement facility name, address and contact number;

iv. Admission date;

v. Last authorized date; and

vi. Total number of days authorized (Days).

4) Concurrent Reviews:

a) Inpatient acute psychiatric level of care reviews shall be conducted telephonically, or through CONTRACTOR's secure provider portal, or as required per MHP-DHCS Agreement requirements and as defined by CCR Title 9 section 1810.100 and 1810.110, at intervals appropriate to the intensity of care.

b) Additional reviews shall be conducted as needed or upon request from CONTRACTOR's Medical Director, and urgent reviews may be conducted when circumstances warrant. Lengthy stays may require consultations with CONTRACTOR's Medical Director.

c) All concurrent reviews, or peer-to-peer reviews shall be documented in CONTRACTOR care management system.

5) Review with Stay Denials:

a) CONTRACTOR shall offer a peer-to-peer MD review to the facility prior to issuing a clinical denial based on not meeting medical necessity for either acute or administrative stay. CONTRACTOR shall not extend the peer-to-peer review determination period beyond 24 hours. Once the peer-to-peer MD review is offered and if Clients assigned facility does not respond or if the attending Medical Doctor does not call for the review, CONTRACTOR shall issue the denial. Determination regarding authorization or denial shall be completed within twenty-four (24) hours from the time of a completed request.

b) All clinical denials are reviewed by CONTRACTOR's Medical Director or Physician Reviewer. Once a final determination has been made, verbal and written notifications shall be sent via agreed upon means to the facility and COUNTY.

c) CONTRACTOR shall utilize the NOABD processes for denials of authorizations for services and report all authorization denials to ADMINISTRATOR.

6) First level Concurrent Review Appeals: CONTRACTOR shall allow Acute Inpatient hospitals to provide additional information and/or appeal the initial concurrent review denial.

J. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Services Paragraph of this Exhibit A to the Contract."

9. Exhibit A, Article X. Staffing, of the Contract is deleted in its entirety and replaced with the following:

" **X. STAFFING**

A. CONTRACTOR shall, at a minimum, provide the following staffing pattern expressed in Full-Time Equivalents (FTEs) continuously throughout the term of the Contract. One (1) FTE shall be equal to an average of forty (40) hours work per week.

ADMINISTRATION	FTEs
Accounting Manager	0.01
Telecom Analyst	0.15
Desktop Support	0.10
Security Specialist	0.19
SUBTOTAL ADMINISTRATION	0.45

PROGRAM

ASO DMC Staffing

Program Director	0.50
Operation Director	0.15
Regional Operation Analyst	0.60
Quality Department Management (Pooled)	0.04
Quality Improvement Coordinator/Grievance and Complaints (Pooled)	0.60
Utilization Review Clinician – Screener (Pooled)	7.00
Clinical Manager	1.00
Clinical Team Lead (Pooled)	1.00
After Hours Supervisor (Pooled Staff)	0.11
After Hours Clinician & DMC Clinician (Pooled Staff)	2.00
Membership Service Representative (Pooled)	7.00
Care Coordinator II (Pooled)	5.00
Credentialing Specialist (Pooled)	0.50
Network Development Manager	0.50
Provider Relations/Dispute Resolution	0.30
Claims Processor (Pooled)	2.00
Claims Supervisor (Pooled Staff)	0.05
Finance - Sr. Accountant	0.10
Database Administrator	0.50
Database Developer	0.30
ASO DMC SUBTOTAL PROGRAM	29.70

Utilization Management Staffing

Quality Analyst (Pooled)	0.40
Regional Ops Analyst	0.40
Manager of Provider Quality (Pooled)	0.50
Supervisor of Utilization Management	1.00
Utilization Management Clinician (Pooled)	11.00
Utilization Management Denials/Correspondence	0.50
Medical Director	1.00
Physician Peer Advisor (Appeals)	0.25
Peer Advisor Scheduler (Pooled)	1.00
Appeals Review & Support	0.65
Clinical Support	2.00
Account Service Coordinator (Audits)	1.00
Behavioral Health Care Manager/Aftercare	0.00
Business Analyst II	1.00
SUBTOTAL UM PROGRAM	24.70
TOTAL PROGRAMS	54.85

B. CONTRACTOR shall provide sufficient administrative and program staffing to ensure its delivery of all services specified in this Exhibit A to the Contract.

C. CONTRACTOR shall, at its own expense, provide and maintain licensed practitioners of the healing arts and supportive personnel to provide all necessary and appropriate psychiatric inpatient hospital utilization management (UM) services.

D. CONTRACTOR agrees Access Line team shall be located in southern California and shall be available to COUNTY Monday through Sunday, from 8:00 a.m. through 6:00 p.m. Pacific Time. CONTRACTOR shall staff an after-hours Access Line team, which shall be available from 6:00 p.m. through 8:00 a.m. Pacific Time.

E. CONTRACTOR shall attempt in good faith to recruit and retain bilingual, culturally competent staff to meet the diverse needs of the community threshold languages as determined

by COUNTY. CONTRACTOR shall also ensure recruitment and retention of staff that have experience in working with diverse populations with specialty needs, including but not limited to, children/adolescents and older adults. When staffing vacancies occur; CONTRACTOR shall attempt to fill with bilingual and bicultural staff. If CONTRACTOR's available candidates require filling those positions with non-bilingual and bicultural staff ADMINISTRATOR will be notified in writing, at least seven (7) calendar days in advance of hiring.

F. CONTRACTOR shall use an interpreter service when a caller speaks a language not spoken by staff, as well as the California Relay Service for hearing impaired members.

G. CONTRACTOR shall maintain personnel files for each staff member, both administrative and programmatic, both direct and indirect, which shall include, but not be limited to, an application for employment, qualifications for the position, documentation of bicultural/bilingual capabilities (if applicable), valid licensure verification, if applicable, and pay rate and evaluations justifying pay increases.

H. CONTRACTOR shall notify ADMINISTRATOR, in writing, within seventy-two (72) hours of any non-pooled staffing vacancies that occur during the term of the Contract. CONTRACTOR's notification shall include at a minimum the following information: employee name(s), position title(s), date(s) of resignation, date(s) of hire, and a description of recruitment activity.

I. CONTRACTOR shall notify ADMINISTRATOR, in writing, at least seven (7) calendar days in advance, of any new non-pooled staffing changes; including promotions, temporary FTE changes and internal or external temporary staffing assignment requests that occur during the term of the Contract.

J. CONTRACTOR shall ensure that all staff are trained and have a clear understanding of all P&Ps. CONTRACTOR shall provide signature confirmation of the P&P training for each staff member and place it in their personnel files.

K. CONTRACTOR shall ensure that all staff, albeit paid or unpaid, complete necessary training prior to discharging duties associated with their titles and any other training necessary to assist CONTRACTOR and COUNTY to be in compliance with prevailing standards of practice as well as State and Federal regulatory requirements.

L. CONTRACTOR shall provide ongoing supervision throughout all shifts to all staff, albeit paid or unpaid, direct line staff or supervisors/directors, to enhance service quality and program effectiveness. Supervision methods should include debriefings and consultation as needed, individual supervision or one-on-one support, and team meetings. Supervision should be provided by a supervisor who has extensive knowledge regarding mental health issues.

M. CONTRACTOR shall ensure that designated staff completes COUNTY's Annual Provider Training and Annual Compliance and Cultural Competency Training.

N. TOKENS – ADMINISTRATOR shall provide CONTRACTOR the necessary number of Tokens for appropriate individual staff to access ADMINISTRATOR designated reporting system at no cost to CONTRACTOR.

1. CONTRACTOR recognizes Tokens are assigned to a specific individual staff member with a unique password. Tokens and passwords shall not be shared with anyone.

2. CONTRACTOR shall ensure information obtained by the use of a Token is used for the sole purpose of this Contract and shall not be shared with any other lines of business without the expressed or written consent of the Client.

3. CONTRACTOR shall request and return tokens pursuant to COUNTY Standard Operating Procedure (SOP) for Processing Token Requests for Administrative Services Organization (ASO).

4. CONTRACTOR shall maintain an inventory of the Tokens, by serial number, date issued/returned and the staff member to whom each is assigned.

5. CONTRACTOR shall indicate in the monthly staffing report, the serial number of the Token for any staff member assigned a Token.

6. CONTRACTOR shall return to ADMINISTRATOR all Tokens under the following conditions:

a. Token of any staff member who no longer supports the Contract;

b. Token of any staff member who no longer requires access to ADMINISTRATOR designated reporting system;

c. Token of any staff member who leaves employment of CONTRACTOR;

d. Token is malfunctioning; or

e. Termination of Contract.

7. CONTRACTOR shall reimburse COUNTY for Tokens lost, stolen, or damaged through acts of negligence.

O. CONTRACTOR and ADMINISTRATOR may mutually agree, in writing, to modify the Staffing Paragraph of this Exhibit A to the Contract."

This Amendment No. 7 modifies the Contract, including its previous amendments, only as expressly set forth herein. Wherever there is a conflict in the terms or conditions between this Amendment No. 7 and the Contract, including its previous amendments, the terms and conditions of this Amendment No. 7 prevail. In all other respects, the terms and conditions of the Contract, including its previous amendments, remain in full force and effect.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this Amendment No.7. If Contractor is a corporation, Contractor shall provide two signatures as follows: 1) the first signature must be either the Chairman of the Board, the President, or any Vice President; 2) the second signature must be either the Secretary, an Assistant Secretary, the Chief Financial Officer, or any Assistant Treasurer. In the alternative, a single corporate signature is acceptable when accompanied by a corporate resolution or by-laws demonstrating the legal authority of the signature to bind the company.

Contractor: Carelon Behavioral Health of California, a California corporation

Briana Duffy	Market President
Print Name	Title
DocuSigned by: Briana Duffy 022ABA4603E24FE...	2/28/2025
Signature	Date

County of Orange, a political subdivision of the State of California

Purchasing Agent/Designee Authorized Signature:

Susan Kessel	
Print Name	Title
Signature	Date

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

Brittany McLean	Deputy County Counsel
Print Name	Title
Signed by: Brittany McLean 71CFE638662E411...	3/2/2025
Signature	Date