AMENDMENT NO. 4
TO
CONTRACT NO. MA-042-18010155
FOR
Administrative Services Organization for Specialty Mental Health Outpatient Services

This Amendment ("Amendment No. 4") to Contract No. MA-042-18010155 for Administrative Services Organization for Specialty Mental Health Outpatient Services is made and entered into on January 1, 2021 ("Effective Date") between Beacon Health Strategies, LLC ("Contractor"), with a place of business at 5665 Plaza Dr., Cypress, CA 90630, 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, on June 23, 2015, the Parties executed Contract No. MA-042-18010155 for Administrative Services Organization for Specialty Mental Health Outpatient Services , effective July 1, 2015 through June 30, 2017, in an amount not to exceed $10,221,360 ("Contract"); and

WHEREAS, on March 28, 2017, the Parties executed Amendment No. 1 to renew the Contract, effective July 1, 2017 through June 30, 2020, in an amount not to exceed $16,073,877, for a revised cumulative contract amount of $26,295,243; and

WHEREAS, on May 8, 2018, the Parties executed Amendment No. 2 to amend the Contract, effective July 1, 2017 through June 30, 2020, to increase the amount not to exceed by $805,114 from $16,073,877 to $16,878,991, for a revised cumulative contract amount of $27,100,357; and

WHEREAS, on June 1, 2018, County exercised the contingency cost increase authority to increase the Period One Maximum Obligation by $45,000, increasing the amount not to exceed to $16,923,991, for a revised cumulative contract amount of $27,145,357; and

WHEREAS, on June 2, 2020, the Parties executed Amendment No. 3 to extend the Contract, effective July 1, 2020 through December 31, 2020, in an amount not to exceed $3,233,540 for the extension period, for a revised cumulative contract amount of $30,333,897; and

WHEREAS, the Parties now desire to enter into this Amendment No. 4 to extend the Contract for County to continue receiving and Contractor to continue providing the services set forth in the Contract and to amend Exhibit A of the Contract.

NOW THEREFORE, Contractor and County agree to amend the Contract as follows:

1. The Contract is extended for a period of six months, effective January 1, 2021 through June 30, 2021, in an amount not to exceed $3,253,539 for this extension period, for a revised cumulative contract amount of $33,587,436; on the amended terms and conditions.

2. Exhibit A, Section III. Budget, subsection A.; Section V. Payments, subsection A. (not including numbered paragraphs); Section VI. Quality Improvement, subsection D.; Section VII. Reports, subsection D.; Section VIII. Services, subsections C.1 Provider Network, D.1 Claims Processing and Adjudication-Network Providers, G.4. Screening and Assessment (a-c), and G.5. Authorization of Services (c-d); and Section IX. Staffing, subsection A., are deleted in their entirety and replaced with the following:

"**III. BUDGET**

A. COUNTY shall pay CONTRACTOR in accordance with the Payments Paragraph in this Exhibit A to the Agreement 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.

	TOTAL
ADMINISTRATIVE COST	
Salaries	$ 14,717
Benefits	3,532
Services and Supplies	6,200
Indirect Costs	98,079
SUBTOTAL ADMINISTRATIVE COST	$122,528
PROGRAM COST	
Salaries	$ 1,050,244
Benefits	252,058
Services and Supplies	117,170
SUBTOTAL PROGRAM COST	$1,419,472
Mental Health Claims	$1,711,539
TOTAL GROSS COST	$3,253,539
REVENUE	
FFP/Other	$1,332,666
State	1,686,473
Federal DMC	207,250

Discretionary	27,150
TOTAL REVENUE	$3,253,539
TOTAL MAXIMUM OBLIGATION	$3,253,539"

"I. PAYMENTS

A. COUNTY shall pay CONTRACTOR monthly, in arrears, at the negotiated amount of $16,347 per month for Indirect Costs and the provisional amount of $525,910 per month for Administrative, Program Direct Costs, and Mental health Claims Costs. All payments are interim payments only, and subject to Final Settlement in accordance with the Cost Report Paragraph of the Agreement 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 Maximum Obligation as specified in the Referenced Contract Provisions of the Agreement 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."

II. QUALITY IMPROVEMENT

D. Performance Outcome Measures

1. CONTRACTOR shall maintain an ongoing performance outcomes monitoring program using information in its provider database, Beneficiary and Network Providers satisfaction surveys, and documentation completed by providers, including but not limited to monitoring of claims utilization patterns, assessment and screening tools, direct peer review and medical record audits. CONTRACTOR shall include in the outcomes monitoring program items required or recommended by the DHCS, as communicated by the ADMINISTRATOR and specified in the Reports Paragraph of this Exhibit A to the Agreement.

a. Objective 1: CONTRACTOR shall achieve, track and evaluate timeliness of access for Beneficiaries and Network Providers calling the Access Line. Timeliness measurements should include, but are not limited to, percentage and number of abandoned member calls to be no more than five percent (5%) of total monthly member calls, percentage and number of member calls answered within thirty (30) seconds to be no less than eighty-five percent (85%) and track call volume, service verification, and timeframe for routine calls from point of authorization to provider appointment.

b. Objective 2: CONTRACTOR shall achieve, track and evaluate utilization trends from claims-based data, identifying quality of care concerns related to over and underutilization patterns. CONTRACTOR will report on the number and outcomes for cases exceeding utilization criteria approved by ADMINISTRATOR and conduct clinical reviews including but not limited to provider-peer consultation, beneficiary rescreening, Level of Care (LOC) reassignment and transition and Medical Director review for no less than twenty percent (20%) of identified outliers within thirty (30) calendar days of each monthly report.

c. Objective 3: CONTRACTOR shall achieve, track and evaluate no less than ninety percent (90%) satisfactory Beneficiary survey results with the customer service provided on the twenty-four (24) hour-seven (7) days a week Access Line. Measurement of satisfaction shall be determined by, but not be limited to; overall satisfaction with informing Beneficiaries of grievance and appeals, State Fair Hearings, accessing services, brief screening for services, and providing referral processes."

"III. REPORTS

D. CONTRACTOR shall provide the records, flat data and program reports listed below to ADMINISTRATOR no later than twenty (20) calendar days following the end of the month being reported or reasonably after being requested by ADMINISTRATOR.

1. MONTHLY
   a. Access Logs for MHP and DMC
   b. Telephone Access Summary: Performance Targets
   c. Authorizations and Timely Access to Services
   d. Lower Level of Care Transitions
   e. Continued Care Review and Consultation
   f. Interpreter Service Utilization
   g. Provider Directory
   h. DMC Referral Summary

2. QUARTERLY
   a. QI-Cost of Service
   b. QI – Beneficiary Satisfaction Survey, ASO's Access Line
   c. QI – Grievance Report
   d. QI – Provider Claims Appeals

e. QI – NOABD and Second Opinion Log for MHP and DMC
f. QI- Service Verification
g. High Volume by Provider
h. Utilization Management Monitoring
i. Network Adequacy Certification Tool
j. Test Call Summary

Period of Quarterly Reports
July 1 through September 30
October 1 through December 31
January 1 through March 31
April 1 through June 30

3. ANNUALLY

QI – Member Satisfaction Survey, ASO's Network Provider

4. 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 the 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."

"**IV. SERVICES**

C. PROVIDER NETWORK

1. DEVELOPMENT AND MANAGEMENT

a. CONTRACTOR shall maintain a Provider Network to provide Specialty Mental Health Services at providers' individual offices or facilities, based upon existing community

needs, including, but not limited to, addressing geographic accessibility and cultural competency, which shall include a multi-lingual/multi-cultural provider or translator supported service availability in threshold languages to include English, Spanish, Farsi, Korean, Arabic, Vietnamese and Mandarin Chinese. 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 Agreement which may include but is not limited to: psychiatrists; licensed psychologists; licensed psychiatric nurse practitioners, MFTs, and LCSW practitioners and other providers as approved by ADMINISTRATOR.

c. CONTRACTOR shall identify and recruit those Network Providers who are serving a specialty population (i.e., age, gender, or cultural specific), or who are in geographic location(s) that would maximize Beneficiary access necessary for the success of the program. Such providers shall be actively pursued to participate in the Provider Network, and their credentialing process shall be expedited.

d. CONTRACTOR shall work closely with ADMINISTRATOR to periodically review LOC appropriateness and reduce the Provider Network to align with fluctuations of ASO level of care referrals.

e. CONTRACTOR shall conduct provider credentialing specified in the Services Paragraph of this Exhibit A to the Agreement. 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 Beneficiaries 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 Beneficiaries 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 Beneficiaries 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 Beneficiaries, their families, and other providers in a collaborative and supportive manner; and

13) Provide services in a managed care environment.

f. 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.

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 will accept either paper or electronic claims including, but not limited to, verification that if the Beneficiary 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. Claims for services shall be requested to be submitted to CONTRACTOR by the Network Providers within thirty (30) days of the date of services but in no case shall CONTRACTOR process any claim that is initially submitted more than ninety (90) days from the date of service, except as required otherwise by law, rules, or regulation as described in the Licenses and Laws Paragraph of this Agreement.

b. 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 and/or CPT codes) and which can be processed completely upon initial entry.

c. 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.

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

4. 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. Require that all Network Providers attempt to collect the Share of Cost from beneficiaries and that reimbursement of claims shall be reduced by the beneficiaries' Share of Cost.

d. 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. Process and pay mental health provider professional fees as they relate to inpatient hospital stays and IMD claims. CONTRACTOR will be provided with a bi-weekly (2 time per week) inpatient and monthly IMD report provided by ADMINISTRATOR.

f. Ensure that the Network Providers notify the Beneficiary of his/her Share of Cost obligation. The Beneficiary 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 Beneficiaries 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 Beneficiary's Share of Cost status. CONTRACTOR will make all reasonable efforts to ensure that all authorized services are eligible for Medi-Cal reimbursement.

h. Ensure that a Beneficiary 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. Maintain procedures regarding the referral of Beneficiaries 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.

l. 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.

G. MENTAL HEALTH SERVICES

4. SCREENING and ASSESSMENT CATEGORIES – As a result of the telephone clinical brief screening, or face-to-face assessment, as appropriate, CONTRACTOR's Access Line clinicians shall refer the Beneficiary for further assessment and treatment according to the following guidelines.

a. Severe/Complex Need for Services - Beneficiaries screened or assessed to have a severe or complex need for Mental Health Services if they meet the state standards for medical necessity for treatment and COUNTY's admission criteria. These Beneficiaries shall be referred to COUNTY for further assessment and care coordination. CONTRACTOR shall ensure a timely and successful referral for these Beneficiaries.

b. Medication Management Need for Services

1) These Beneficiaries shall meet medical necessity criteria for treatment or meet COUNTY admission criteria. These Beneficiaries will either be able to attend scheduled outpatient office appointments, or be in a facility such as a Board and Care. Beneficiaries in a SNF or in some cases in an ER shall be eligible for psychiatric consultation/treatment. Authorization and process shall be determined with ADMINISTRATOR.

2) Beneficiaries referred from COUNTY, no additional screening or assessment shall be required by CONTRACTOR.

3) Annual or semi-annual re-authorization through CONTRACTOR shall be required of Network Providers to continue these services for beneficiaries.

4) CONTRACTOR shall collaborate with physical health care providers to ensure the most appropriate level of medication management is provided.

c. Episodic Need for Services - Beneficiaries referred to CONTRACTOR's Network of Providers for services shall receive up to a total of twelve (12) psychiatry or a maximum of twenty-six (26) routine psychotherapy treatment hours to include assessment within a period of six months. The parties agree that, due to the episodic nature of illness experienced by the Specialty Mental Health population, it is expected that many Beneficiaries' needs shall be met by these initial hours authorized. Additional hours of service will require Continued Care Review (CCR) by CONTRACTOR.

5. AUTHORIZATION OF SERVICES

c. CCR - If a Beneficiary is identified through CONTRACTOR's automated UM monitoring report as continuing or exceeding treatment allowed in Services Paragraph of this

Exhibit A to the Agreement, an Access Line clinician will conduct additional review and/or assessment via CCR to determine medical necessity and level of care remain appropriate to the beneficiaries needs and the planned treatment will potentially improve beneficiaries 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 beneficiary 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) The Access Line clinician determines the Beneficiary may require COUNTY level of care and may be better served by COUNTY, the Beneficiary 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 back to CONTRACTOR for services.

3) 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 Beneficiary provided that justification includes utilizing the minimum criteria detailed in the Services Paragraph of this Exhibit A to the Agreement.

4) 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.

d. Outpatient Psychiatric Medication and Adult Psychotherapy Services

1) Initial treatment authorizations for Beneficiaries 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) The 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."

"V. STAFFING

A. CONTRACTOR shall, at a minimum, provide the following staffing pattern expressed in Full-Time Equivalents (FTEs) continuously throughout the term of the Agreement between January 1, 2021 through June 30, 2021. One (1) FTE shall be equal to an average of forty (40) hours work per week.

ADMINISTRATION	FTEs
Accounting Manager	0.02
Tech. Ops	0.18
Application Developer	0.13
EDI Specialist	0.03
Data Base Developer/Analyst	0.01
SUBTOTAL ADMINISTRATION	0.37
PROGRAM	
Program Director	0.30
HR Representative	0.04
Project Manager	0.35
Operation Director	0.35
Clinical Manager	1.00
Clinical Supervisor	2.00
Utilization Review Clinician	5.00
Membership Service Representative	7.00
Medical Director	0.26
ASO Network Manager	1.00
Claims Appeal Manager	0.15
Claims Data Specialist (Pooled Staff)	3.00
Credentialing Specialist (Pooled Staff)	0.50
Quality Improvement Coordinator	0.50
Care Coordinator	6.00
After Hours Clinician & DMC Clinician (Pooled Staff)	1.75
Data Base Developer	0.25
Data Base Administrator	0.50
Sr. Accountant	0.20
After Hours Member Service Representative	2.50

Customer Service Supervisor	1.00
Provider Relations Specialist	0.50
Provider Dispute Specialist	1.00
Regulatory Ops Analyst	1.00
SUBTOTAL PROGRAM	36.15
TOTAL FTEs	36.52”

This Amendment No. 4 modifies the Contract only as expressly set forth herein. Wherever there is a conflict in the terms or conditions between this Amendment No. 4 and the Contract, including Amendments No. 1, No. 2, and No. 3, the terms and conditions of this Amendment No. 4 prevail. In all other respects, the terms and conditions of the Contract, including Amendments No. 1, No. 2, and No. 3 not specifically changed by this Amendment No. 4 remain in full force and effect.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this Amendment No. 4. If Contractor is a corporation, Contractor shall provide two signatures as follows: 1) the first signature must be either the Chairman of the Board, President, or any Vice President; 2) the second signature must be that of 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: Beacon Health Strategies, LLC

Daniel Risku	Executive Vice President & General Counsel
Print Name	Title
DocuSigned by: Daniel Risku A4E61E3735E448E...	11/17/2020
Signature	Date

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

Purchasing Agent/Designee Authorized Signature:

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
DocuSigned by: Brittany McLean 9713A4061D4343D...	11/17/2020
Signature	Date