FIRST AMENDMENT TO AGREEMENT FOR PROVISION OF
ADMINISTRATIVE SERVICES ORGANIZATION
FOR
SPECIALTY MENTAL HEALTH OUTPATIENT SERVICES
BETWEEN
COUNTY OF ORANGE
AND
BEACON HEALTH STRATEGIES, LLC
JULY 1, 2017 THROUGH JUNE 30, 2020

THE FIRST AMENDMENT TO AGREEMENT entered into as of this 1st day of July 1, 2018 (effective date), is by and between the COUNTY OF ORANGE, a political subdivision of State of California (COUNTY), and BEACON HEALTH STRATEGIES, LLC, a Massachusetts limited liability company (CONTRACTOR). COUNTY and CONTRACTOR may sometimes be referred to herein individually as "Party" or collectively as "Parties." The Original Agreement and this First Amendment are and shall be administered by the County of Orange Health Care Agency (ADMINISTRATOR).

W I T N E S S E T H:

WHEREAS, the State of California Managed Care Plan for Medi-Cal Mental Health Services, dated June 1, 1994, defines and describes the principles and elements of the managed mental health care design for the public mental health system; and

WHEREAS, COUNTY under the authority of Sections 5775, et seq. of the Welfare and Institutions Code and the regulations adopted pursuant thereto, is the Local Mental Health Managed Care Administrator for Specialty Medi-Cal Mental Health Services; and

WHEREAS, on the 1st day of July 2017, COUNTY and CONTRACTOR previously entered into that certain Agreement for the provision of Administrative Services Organization for Specialty Mental Health Outpatient Services described herein to the residents of Orange County Services for the period July 1, 2017 through June 30, 2020; and

WHEREAS, on or about July 1, 2018, ADMINISTRATOR intends to authorize an increase of the Agreement amount by $402,557 for Period Two and Period Three, revising the Maximum Obligations for Period Two and for Period Three from $5,357,959 to $5,760,516 for a revised Total Maximum Obligation of $16,878,991; and

WHEREAS, CONTRACTOR desires to accept the additional funding and agrees to provide additional Administrative Services Organization for Specialty Mental Health Outpatient Services pursuant to the terms and conditions of the original Agreement and scope of work;

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NOW, THEREFORE, in consideration of the mutual covenants, benefits, and promises contained herein, COUNTY and CONTRACTOR do hereby agree as follows:

1. Page 4, lines 5 through 9, Referenced Contract Provisions, of the Agreement are amended to read as follows:

"Maximum Obligation:

Period One Maximum Obligation:	$ 5,357,959
Period Two Maximum Obligation:	5,760,516
Period Three Maximum Obligation:	5,760,516
TOTAL MAXIMUM OBLIGATION:	$16,878,991"

2. Paragraph IV, Compliance of the Agreement is amended to read as follows:

"A. COMPLIANCE PROGRAM – ADMINISTRATOR has established a Compliance Program for the purpose of ensuring adherence to all rules and regulations related to federal and state health care programs.

1. ADMINISTRATOR shall provide CONTRACTOR with a copy of the policies and procedures relating to ADMINISTRATOR's Compliance Program, Code of Conduct and access to General Compliance and Annual Provider Trainings.

2. CONTRACTOR has the option to provide ADMINISTRATOR with proof of its own Compliance Program, Code of Conduct and any Compliance related policies and procedures. CONTRACTOR's Compliance Program, Code of Conduct and any related policies and procedures shall be verified by ADMINISTRATOR's Compliance Department to ensure they include all required elements by ADMINISTRATOR's Compliance Officer as described in in this Paragraph IV (COMPLIANCE). These elements include:

a. Designation of a Compliance Officer and/or compliance staff.
b. Written standards, policies and/or procedures.
c. Compliance related training and/or education program and proof of completion.
d. Communication methods for reporting concerns to the Compliance Officer.
e. Methodology for conducting internal monitoring and auditing.
f. Methodology for detecting and correcting offenses.
g. Methodology/Procedure for enforcing disciplinary standards.

3. If CONTRACTOR does not provide proof of its own Compliance program to ADMINISTRATOR, CONTRACTOR shall acknowledge to comply with ADMINISTRATOR's Compliance Program and Code of Conduct, the CONTRACTOR shall submit to the ADMINISTRATOR within thirty (30) calendar days of execution of this Agreement a signed acknowledgement that CONTRACTOR shall comply with ADMINISTRATOR's Compliance Program and Code of Conduct.

4. If CONTRACTOR elects to have its own Compliance Program, Code of Conduct and any Compliance related policies and procedures review by ADMINISTRATOR, then CONTRACTOR shall submit a copy of its compliance Program, code of Conduct and all relevant policies and procedures to ADMINISTRATOR within thirty (30) calendar days of execution of this Agreement. ADMINISTRATOR's Compliance Officer, or designee, shall review said documents within a reasonable time, which shall not exceed forty five (45) calendar days, and determine if CONTRACTOR's proposed compliance program and code of conduct contain all required elements to the ADMINISTRATOR's satisfaction as consistent with the HCA's Compliance Program and Code of Conduct. ADMINISTRATOR shall inform CONTRACTOR of any missing required elements and CONTRACTOR shall revise its compliance program and code of conduct to meet ADMINISTRATOR's required elements within thirty (30) calendar days after ADMINISTRATOR's Compliance Officer's determination and resubmit the same for review by the ADMINISTRATOR.

5. Upon written confirmation from ADMINISTRATOR's Compliance Officer that the CONTRACTOR's compliance program, code of conduct and any Compliance related policies and procedures contain all required elements, CONTRACTOR shall ensure that all Covered Individuals relative to this Agreement are made aware of CONTRACTOR's compliance program, code of conduct, related policies and procedures and contact information for the ADMINISTRATOR's Compliance Program.

B. SANCTION SCREENING – CONTRACTOR shall screen all Covered Individuals employed or retained to provide services related to this Agreement monthly to ensure that they are not designated as Ineligible Persons, as pursuant to this Agreement. Screening shall be conducted against the General Services Administration's Excluded Parties List System or System for Award Management, the Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities, the California Medi-Cal Suspended and Ineligible Provider List, and the Social Security Administration Death Master File and/or any other list or system as identified by ADMINISTRATOR.

1. For purposes of this Paragraph IV (COMPLIANCE), Covered Individuals includes all employees, interns, volunteers, contractors, subcontractors, agents, and other persons who provide health care items or services or who perform billing or coding functions on behalf of ADMINISTRATOR. Notwithstanding the above, this term does not include part-time or per-diem employees, contractors, subcontractors, agents, and other persons who are not reasonably expected to work more than one hundred sixty (160) hours per year; except that any such individuals shall become Covered Individuals at the point when they work more than one hundred sixty (160) hours during the calendar year. CONTRACTOR shall ensure that all Covered Individuals relative to this Agreement are made aware of ADMINISTRATOR's Compliance Program, Code of Conduct and related policies and procedures (or CONTRACTOR's own compliance program, code of conduct and related policies and procedures if CONTRACTOR has elected to use its own).

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2. An Ineligible Person shall be any individual or entity who:

a. is currently excluded, suspended, debarred or otherwise ineligible to participate in federal and state health care programs; or

b. has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the federal and state health care programs after a period of exclusion, suspension, debarment, or ineligibility.

3. CONTRACTOR shall screen prospective Covered Individuals prior to hire or engagement. CONTRACTOR shall not hire or engage any Ineligible Person to provide services relative to this Agreement.

4. CONTRACTOR shall screen all current Covered Individuals and subcontractors semi-annually to ensure that they have not become Ineligible Persons. CONTRACTOR shall also request that its subcontractors use their best efforts to verify that they are eligible to participate in all federal and State of California health programs and have not been excluded or debarred from participation in any federal or state health care programs, and to further represent to CONTRACTOR that they do not have any Ineligible Person in their employ or under contract.

5. Covered Individuals shall be required to disclose to CONTRACTOR immediately any debarment, exclusion or other event that makes the Covered Individual an Ineligible Person. CONTRACTOR shall notify ADMINISTRATOR immediately if a Covered Individual providing services directly relative to this Agreement becomes debarred, excluded or otherwise becomes an Ineligible Person.

6. CONTRACTOR acknowledges that Ineligible Persons are precluded from providing federal and state funded health care services by contract with COUNTY in the event that they are currently sanctioned or excluded by a federal or state law enforcement regulatory or licensing agency. If CONTRACTOR becomes aware that a Covered Individual has become an Ineligible Person, CONTRACTOR shall remove such individual from responsibility for, or involvement with, COUNTY business operations related to this Agreement.

7. CONTRACTOR shall notify ADMINISTRATOR immediately if a Covered Individual or entity is currently excluded, suspended or debarred, or is identified as such after being sanction screened. Such individual or entity shall be immediately removed from participating in any activity associated with this Agreement. ADMINISTRATOR will determine appropriate repayment from, or sanction(s) to CONTRACTOR for services provided by ineligible person or individual. CONTRACTOR shall promptly return any overpayments within forty-five (45) business days after the overpayment is verified by ADMINISTRATOR.

C. GENERAL COMPLIANCE TRAINING – ADMINISTRATOR shall make General Compliance Training available to Covered Individuals.

1. CONTRACTORS that have acknowledged to comply with ADMINISTRATOR's Compliance Program shall use its best efforts to encourage completion by all Covered Individuals;

provided, however, that at a minimum CONTRACTOR shall assign at least one (1) designated representative to complete the General Compliance Training when offered.

2. Such training will be made available to Covered Individuals within thirty (30) calendar days of employment or engagement.

3. Such training will be made available to each Covered Individual annually.

4. ADMINISTRATOR will track training completion while CONTRACTOR shall provide copies of training certification upon request.

5. Each Covered Individual attending a group training shall certify, in writing, attendance at compliance training. ADMINISTRATOR shall provide instruction on group training completion while CONTRACTOR shall retain the training certifications. Upon written request by ADMINISTRATOR, CONTRACTOR shall provide copies of the certifications.

D. SPECIALIZED PROVIDER TRAINING – ADMINISTRATOR shall make Specialized Provider Training, where appropriate, available to Covered Individuals.

1. CONTRACTOR shall ensure completion of Specialized Provider Training by all Covered Individuals relative to this Agreement.

2. Such training will be made available to Covered Individuals within thirty (30) calendar days of employment or engagement.

3. Such training will be made available to each Covered Individual annually.

4. ADMINISTRATOR will track online completion of training while CONTRACTOR shall provide copies of the certifications upon request.

5. Each Covered Individual attending a group training shall certify, in writing, attendance at compliance training. ADMINISTRATOR shall provide instructions on completing the training in a group setting while CONTRACTOR shall retain the certifications. Upon written request by ADMINISTRATOR, CONTRACTOR shall provide copies of the certifications.

E. MEDICAL BILLING, CODING, AND DOCUMENTATION COMPLIANCE STANDARDS

1. CONTRACTOR shall take reasonable precaution to ensure that the coding of health care claims, billings and/or invoices for same are prepared and submitted in an accurate and timely manner and are consistent with federal, state and county laws and regulations. This includes compliance with federal and state health care program regulations and procedures or instructions otherwise communicated by regulatory agencies including the Centers for Medicare and Medicaid Services or their agents.

2. CONTRACTOR shall not submit any false, fraudulent, inaccurate and/or fictitious claims for payment or reimbursement of any kind.

3. CONTRACTOR shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, CONTRACTOR shall use proper billing codes which accurately describes the services provided and must ensure compliance with all billing and documentation requirements.

4. CONTRACTOR shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified.

5. CONTRACTOR shall promptly return any overpayments within forty-five (45) business days after the overpayment is verified by the ADMINISTRATOR.

6. CONTRACTOR shall meet the HCA MHP Quality Management Program Standards and participate in the quality improvement activities developed in the implementation of the Quality Management Program.

7. CONTRACTOR shall comply with the provisions of the ADMINISTRATOR's Cultural Competence Plan submitted and approved by the State. ADMINISTRATOR shall update the Cultural Competence Plan and submit the updates to the State for review and approval annually. (CCR, Title 9, §1810.410.subds. (c)-(d).)

F. Failure to comply with the obligations stated in this Paragraph IV (COMPLIANCE) shall constitute a breach of the Agreement on the part of CONTRACTOR and ground for COUNTY to terminate the Agreement. Unless the circumstances require a sooner period of cure, CONTRACTOR shall have thirty (30) calendar days from the date of the written notice of default to cure any defaults grounded on this Paragraph IV (COMPLIANCE) prior to ADMINISTRATOR's right to terminate this Agreement on the basis of such default."

3. Paragraph XIV, Licenses and Laws of the Agreement is amended to read as follows:

"A. CONTRACTOR, its officers, agents, employees, affiliates, and subcontractors shall, throughout the term of this Agreement, maintain all necessary licenses, permits, approvals, certificates, accreditations, waivers, and exemptions necessary for the provision of the services hereunder and required by the laws, regulations and requirements of the United States, the State of California, COUNTY, and all other applicable governmental agencies. CONTRACTOR shall notify ADMINISTRATOR immediately and in writing of its inability to obtain or maintain, irrespective of the pendency of any hearings or appeals, permits, licenses, approvals, certificates, accreditations, waivers and exemptions. Said inability shall be cause for termination of this Agreement.

B. ENFORCEMENT OF CHILD SUPPORT OBLIGATIONS

1. CONTRACTOR agrees to furnish to ADMINISTRATOR within thirty (30) calendar days of the award of this Agreement:

a. In the case of an individual contractor, his/her name, date of birth, social security number, and residence address;

b. In the case of a contractor doing business in a form other than as an individual, the name, date of birth, social security number, and residence address of each individual who owns an interest of ten percent (10%) or more in the contracting entity;

c. A certification that CONTRACTOR has fully complied with all applicable federal and state reporting requirements regarding its employees;

d. A certification that CONTRACTOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

2. Failure of CONTRACTOR to timely submit the data and/or certifications required by Subparagraphs 1.a., 1.b., 1.c., or 1.d. above, or to comply with all federal and state employee reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Agreement; and failure to cure such breach within sixty (60) calendar days of notice from COUNTY shall constitute grounds for termination of this Agreement.

3. It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders, or as permitted by federal and/or state statute.

C. CONTRACTOR shall comply with all applicable governmental laws, regulations, and requirements as they exist now or may be hereafter amended or changed. These laws, regulations, and requirements shall include, but not be limited to, the following:

1. ARRA of 2009.
2. WIC, Division 5, Community Mental Health Services.
3. WIC, Division 6, Admissions and Judicial Commitments.
4. WIC, Division 7, Mental Institutions.
5. HSC, §§1250 et seq., Health Facilities.
6. PC, §§11164-11174.3, Child Abuse and Neglect Reporting Act.
7. CCR, Title 9, Rehabilitative and Developmental Services.
8. CCR, Title 17, Public Health.
9. CCR, Title 22, Social Security.
10. CFR, Title 42, Public Health.
11. CFR, Title 45, Public Welfare.
12. USC Title 42. Public Health and Welfare.
13. Federal Social Security Act, Title XVIII and Title XIX Medicare and Medicaid.
14. 42 USC §12101 et seq., Americans with Disabilities Act of 1990.
15. 42 USC §1857, et seq., Clean Air Act.
16. 33 USC 84, §308 and §§1251 et seq., the Federal Water Pollution Control Act.
17. 31 USC 7501.70, Federal Single Audit Act of 1984.
18. Policies and procedures set forth in Mental Health Services Act.
19. Policies and procedures set forth in DHCS Letters.
20. HIPAA privacy rule, as it may exist now, or be hereafter amended, and if applicable.

31 USC 7501 – 7507, as well as its implementing regulations under 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

21. 42 CFR 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
22. 42 CFR 54, Charitable choice regulations applicable to states receiving substance abuse prevention and treatment block grants and/or projects for assistance in transition from homelessness grants.
23. Orange County Medi-Cal Mental Health Managed Care Plan.

D. CONTRACTOR shall at all times be capable and authorized by the State of California to provide treatment and bill for services provided to Medi-Cal eligible clients while working under the terms of this Agreement."

4. Subparagraph III. A. of Exhibit A to the Agreement is amended to read as follows:

"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.

	PERIOD ONE	PERIOD TWO	PERIOD THREE	TOTAL
ADMINISTRATIVE COST				
Salaries	$ 48,629	$ 48,629	$ 48,629	$ 145,887
Benefits	10,212	10,212	10,212	30,636
Services and Supplies	15,529	15,529	15,529	46,587
Indirect Costs	176,989	196,158	196,158	569,305
SUBTOTAL ADMINISTRATIVE COST	$ 251,359	$ 270,528	$ 270,528	$ 792,415
PROGRAM COST				
Salaries	$1,153,685	$1,408,540	$1,408,540	$ 3,970,765
Benefits	242,274	295,794	295,794	833,862
Services and Supplies	287,563	362,576	362,576	1,012,715
SUBTOTAL PROGRAM COST	$1,683,522	$2,066,910	$2,066,910	$ 5,817,342
Mental Health Claims	$3,423,078	$3,423,078	$3,423,078	$10,269,234
TOTAL GROSS COST	$5,357,959	$5,760,516	$5,760,516	$16,878,991

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REVENUE				
FFP	$2,411,082	$2,411,082	$2,411,082	$7,233,246
EPSDT	267,898	267,898	267,898	803,694
SAPT	0	402,557	402,557	905,114
Discretionary	2,678,979	2,678,979	2,678,979	8,036,931
TOTAL REVENUE	$5,357,959	$5,760,516	$5,760,516	$16,878,991
TOTAL MAXIMUM OBLIGATION	$5,357,959	$5,760,516	$5,760,516	$16,878,991"

5. Subparagraph V. of Exhibit A to the Agreement is amended to read as follows:

"A. COUNTY shall pay CONTRACTOR monthly, in arrears, at the negotiated amount of $14,749 per month for Indirect Costs and the provisional amount of $431,748 per month for Administrative, Program Direct Costs, and Mental health Claims Costs for Period One and at the negotiated amount of $16,347 per month for Indirect Costs and the provisional amount of $463,697 per month for Administrative, Program Direct Costs, and Mental health Claims Costs for Period Two and Period Three. 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.

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

2. CONTRACTOR, or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that include provision for the suspension of payments to a network provider for which the State, or CONTRACTOR, determines there is credible allegation of fraud.

3. 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 Agreement. ADMINISTRATOR shall use the Expenditure and Revenue Report to determine payment to CONTRACTOR as specified in Subparagraphs A.2. and A.3., below.

4. 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's and the year-to-date actual cost incurred by CONTRACTOR.

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

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

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

6. Subparagraph VII. of Exhibit A to the Agreement is amended to read as follows:

"CONTRACTOR shall maintain records, create and analyze statistical reports as required by ADMINISTRATOR and DHCS in a format approved by, ADMINISTRATOR. CONTRACTOR will provide ADMINISTRATOR with the following:

A. FISCAL

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 Agreement. 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.

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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 Agreement. 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.

B. 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.

C. PROGRAMMATIC REPORTS – CONTRACTOR shall submit monthly separate Specialty Mental Health Services (SMH) and Drug Medi-Cal Services (DMC) 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.

D. CONTRACTOR shall provide records and program reports, as listed below, shall be received by ADMINISTRATOR no later than twenty (20) calendar days following the end of the month being reported or as requested by ADMINISTRATOR. Annual reports do not apply to Drug Medi-Cal Services.

1. MONTHLY
    a. Access Logs (SMH and DMC)
    b. Telephone Access Summary: Performance Targets (SMH and DMC)
    c. Authorizations and Access to Services
    d. Lower Level of Care Transitions
    e. Re-authorization of Services

2. QUARTERLY
   a. Demographics – Network Providers
   b. QI – Beneficiary Satisfaction Survey, ASO's Access Line (SMH and DMC)
   c. QI – Grievance Report
   d. QI – Provider Claims Appeals
   e. QI – NOA and Second Opinion Log
   f. High Utilizer by Provider
   g. Timeliness of Utilization Management Decision Making

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

3. ANNUAL
   a. QI – Member Satisfaction Survey, ASO's Network Providers
   b. QI – Provider Satisfaction Survey
   c. QI – Committee Review

4. ACCESS LOG (SMH) – 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.

5. ACCESS LOG (DMC) – CONTRACTOR shall develop and maintain a written Access Log of all requests for Drug Medi-Cal 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 (MH or SUD), call status (urgent, routine), if the request is an initial request for Drug Medi-Cal Services, and the disposition of the request (referrals to DMC-ODS approved facilities or referrals to other treatment services) and other resources. 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. A separate Access Log for DMC requests will be required.

6. 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.

a. ADMINISTRATOR shall provide the CONTRACTOR with a monthly MEDS Extract file (MMFE) when available from DHCS.

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

c. 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.

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

e. 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 in a timely manner.

f. 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 Beneficiary or ADMINISTRATOR. Confidentiality procedures shall meet all local, state, and federal requirements.

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

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E. 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.

F. CONTRACTOR shall provide ADMINISTRATOR with a report key, established by CONTRACTOR, as agreed upon by ADMINISTRATOR that describes each report, its purpose and usefulness. CONTRACTOR shall update the report key when reports are added or deleted and provide updated report key to ADMINISTRATOR within thirty (30) days.

G. CONTRACTOR shall upon ADMINISTRATORS request revise and make changes to all reports as needed.

H. 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.

I. 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.

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

7. Subparagraph VIII. of Exhibit A to the Agreement is amended to read as follows:

"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 Agreement.

5665 Plaza Drive, Suite 400
Cypress, California 90630

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

C. PROVIDER NETWORK

1. DEVELOPMENT AND MANAGEMENT

a. CONTRACTOR shall maintain a Provider Network to provide Specialty Mental Health Services at provider's individual offices or facilities, based upon existing community needs, including, but not limited to, addressing geographic accessibility and cultural competency, which shall include service availability in threshold languages to include English, Spanish, Farsi, Korean, Arabic, and

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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 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 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.

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 Agreement.

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 shall be responsible for 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 Agreement;

7) History of professional liability claims; and

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

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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 Beneficiary 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 provides for 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 CONTRACTOR Beneficiaries 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 Beneficiaries 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 publish provider newsletters, which shall serve to update providers on operational and clinical requirements, and provide clarification on contractual issues. A copy of such newsletters shall be sent to ADMINISTRATOR.

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

a. CONTRACTOR shall make its best efforts to provide services pursuant to the Agreement 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.

b. 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.

c. CONTRACTOR shall actively solicit providers for its network to ensure that Beneficiary 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 Beneficiary satisfaction, shall be conducted in order to identify any network needs that might arise. In cases where a Beneficiary's request for a culture-specific provider cannot be met, CONTRACTOR shall conduct an immediate provider search to meet the Beneficiary's need and shall begin an expedited credentialing process in order to add the identified provider to the network. Qualified interpreters shall not be intended to replace bilingual professionals, but may be utilized only when no alternative is immediately available. A qualified interpreter shall be defined as a person not trained in mental health services that have 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 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.

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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. Share of Cost – CONTRACTOR shall 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. CONTRACTOR shall have access to the Medi-Cal Eligibility Website and MEDS to determine client eligibility and any Share of Cost remaining for the date of service.

e. CONTRACTOR shall have access to the weekly inpatient and monthly IMD list as they relate to paying inpatient and IMD claims. These lists will be provided by ADMINISTRATOR.

f. CONTRACTOR shall 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. CONTRACTOR shall 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. CONTRACTOR shall 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.

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.

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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.

5. Other Health Coverage – CONTRACTOR shall:

a. Direct Beneficiaries 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.

b. CONTRACTOR shall direct Beneficiaries 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.

c. CONTRACTOR shall direct Beneficiaries 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.

d. CONTRACTOR shall direct Beneficiaries 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.

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

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

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

6. 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 Beneficiary 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 Provider Appeal Process. CONTRACTOR's appeal process shall include review by CONTRACTOR's Director of Clinical Services or designee, CONTRACTOR's Medical Director or designee, and CONTRACTOR's Utilization Management Committee. 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.

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

1. 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 the CONTRACTOR to the Network Provider.

2. CONTRACTOR shall also:

a. Ensure that all billing activity is 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 the 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 CONTRACTORS 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 ADMINISTRATOR during any system/application changes or enhancements to ensure continuity of compliant operations;

e. Ensure Federal HIPAA compliance;

f. Have ability to compile and electronically transmit Medi-Cal 837 claim files to ADMINISTRATOR 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;

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

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

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

k. Conduct reviews and audits to see that claims submissions by Network Providers and payments for approved claims are accurate. 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; they will 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 the CONTRACTOR will 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.

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

4. 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 Agreement. Further, CONTRACTOR agrees that the funds provided hereunder will not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

5. CONTRACTOR shall provide effective Administrative management of the budget, staffing, recording, and reporting portion of the Agreement 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 Agreement;

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.

F. 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. This line may not be a taped recording, and must have a live operator at all times.

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

3. CONTRACTOR's Access Line clinicians shall speak the languages of most of the enrollees. 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.

G. MENTAL HEALTH SERVICES – SPECIALTY MENTAL HEALTH SERVICES

1. SCREENING

a. CONTRACTOR shall provide the Beneficiary with a very brief screening to first determine if the Beneficiary is seeking mental health services followed by verification of Medi-Cal eligibility.

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 Beneficiaries 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 beneficiaries as part of care coordination services. Clinicians will link beneficiaries with complex or co-morbid conditions to appropriate care, focus on the integration of mental health and primary care, and help beneficiaries 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 Beneficiary 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 Beneficiary being a danger to himself/herself or others or an immediate inability of the Beneficiary to provide for, or utilize food, shelter or clothing as a result of a mental disorder. These calls must be linked within two (2) hours.

2) Urgent services shall be indicated when a situation experienced by a Beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Beneficiaries 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 twenty-four (24) hours.

3) CONTRACTOR must obtain confirmation that any caller assessed as requiring emergent or urgent care has been appropriately connected to COUNTY or police. If the Beneficiary did not show up to the appointed session/evaluation, CONTRACTOR shall contact the Beneficiary 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 a Network Provider for an appointment to be offered within fourteen (14) calendar days of the referral. Routine services shall be indicated when a Beneficiary'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 Beneficiary'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. Beneficiaries requesting mental health services shall not be denied services solely based upon a telephone clinical screening. Should it not be possible to determine a Beneficiary's needs,

during the brief telephone clinical screening, CONTRACTOR shall take further steps to ensure beneficiaries are referred to the most appropriate level of care by referring the Beneficiary for a face-to-face assessment by an approved Network Provider.

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

2) During the face-to-face assessment, psychological testing may be used to assist in the diagnostic evaluation process in cases where the clinical assessment alone is insufficient to determine appropriate diagnosis and treatment needs.

a) CONTRACTOR shall require that testing be provided only by licensed clinical psychologists.

b) Network Providers requesting psychological testing related to treatment decisions must submit a request, to CONTRACTOR, which shall be reviewed by CONTRACTOR.

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 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 Medical/Surgical hospital 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 six (6) treatment hours to include assessment. 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 six (6) initial hours authorized. Additional hours of service will require authorization by CONTRACTOR through an automated reauthorization process.

d. Out of COUNTY Services - CONTRACTOR shall be responsible for processing and paying claims for services provided to COUNTY Beneficiaries who meet medical necessity for treatment and may require services while out of 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 COUNTY.

2) COUNTY will cooperate with the CONTRACTOR in connection with providing authorization for services to Beneficiaries 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 COUNTY at COUNTY's discretion, after notification to CONTRACTOR, at any point in the treatment.

e. Other Need for Services – Beneficiaries shall be referred to their MCP or PCP for treatment, if beneficiary'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 NOA-A, if applicable and, beyond assessment, are not the responsibility of COUNTY or CONTRACTOR.

f. Excluded Diagnosis – A Beneficiary's face-to-face assessment determines that the Beneficiary has an excluded diagnosis and therefore does not meet medical necessity criteria for receiving treatment from either COUNTY or CONTRACTOR, and a NOA-A shall be provided, if applicable.

1) CONTRACTOR may have Network Providers who are capable of treating these Beneficiaries and can bill the State for these excluded diagnoses under the remaining FFS system. CONTRACTOR shall identify such providers within CONTRACTOR's network and shall make the appropriate referral in a timely manner.

2) CONTRACTOR may also refer these Beneficiaries to those community clinics not under contract with COUNTY to provide mental health services for these Beneficiaries.

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5. AUTHORIZATION OF SERVICES

a. Inpatient and IMD Attending – These Beneficiaries shall meet medical necessity for treatment and COUNTY admission criteria; therefore, no additional screening shall be required by CONTRACTOR. CONTRACTOR shall be responsible for reimbursing attending psychiatrists. Claims for services for these Beneficiaries will be processed in accordance with the following:

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

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

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 will be advised in writing by CONTRACTOR that the cumulative claims exceeding $1,000 will be denied unless provider becomes a Network Provider in the CONTRACTOR's network. CONTRACTOR will also advise Network Providers that they must obtain authorization from CONTRACTOR for ongoing services. These services will be authorized following the in-county benefit guidelines.

3) Children and adolescent beneficiaries 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. PAR - If a Network Provider determines that the Beneficiary requires more hours of treatment than initially allowed in Services Paragraph of this Exhibit A to the Agreement, a PAR shall be submitted to CONTRACTOR for review and authorization of subsequent hours.

1) The PAR 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.

2) The information provided from the PAR shall be reviewed by the Access Line clinicians and if the Beneficiary's need can be met with an additional authorization, up to an additional three (3) hours may be authorized. If, however, 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 PAR 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) New authorizations for Beneficiaries shall be allowed up to six (6) visits for the initial six (6) months. Additional hours of service will require re-authorization by CONTRACTOR.

2) Subsequent authorizations for ongoing services shall be allowed up to twelve (12) visits for the subsequent twelve (12) months. 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 PCPs:

a. Timely coordination and referral.

b. Timely exchange of information.

c. Education of both Beneficiaries 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 Beneficiary.

1) A part of CONTRACTOR's PAR process shall include collecting and evaluating the Beneficiary's medication regimen. All medication monitoring forms shall be made available to the PCP's upon request.

2) If CONTRACTOR's Access Line clinicians discover potential coordination of medication concerns between the treating psychiatrist and the PCP, telephone calls shall be placed to both providers 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 Beneficiaries 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 Beneficiary's PCP. Upon appropriate Beneficiary consent, Network Providers shall coordinate with the PCP regarding a patient concern. With proper Beneficiary consent, CONTRACTOR shall release the information from the Network Provider to the 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 Beneficiaries about treatments that may impact their service delivery, and to update the 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 Beneficiary shall be notified by CONTRACTOR in writing by sending a NOA form.

1) If services are denied, CONTRACTOR shall send an NOA-A form.

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

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

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

c. COUNTY shall supply CONTRACTOR with NOA forms. All NOA forms include instructions regarding second opinion and appeals processes.

1) A Beneficiary may request a second opinion. CONTRACTOR is responsible for second opinions for NOAs issued by CONTRACTOR.

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

3) The expedited appeal process shall include a first level review of the case by the CONTRACTOR's Medical Director (or other physician designee) within twenty-four (24) hours of receipt of the oral or written appeal from the provider. If the Network Provider is still unsatisfied, he/she shall be referred to COUNTY or may pursue the State Medi-Cal Fair Hearing process.

4) Should the CONTRACTOR fail to respond to the appeal or expedited appeal within the mandated timelines, the CONTRACTOR shall send the Beneficiary a NOA-D form.

H. MENTAL HEALTH SERVICES - DRUG MEDI-CAL SERVICES

1. SCREENING – CONTRACTOR will include telephonic screenings for Drug Medi-Cal Services. The Administrative Services Organization will be a primary access point for OC Medi-Cal beneficiaries to link to substance abuse services through the Drug Medi-Cal Organized Delivery System

(DMC-ODS). The CONTRACTOR will expand the 24/7 hour Access Line call center to include DMC-ODS screening for services.

2. BENEFICIARY ACCESS LINE (BAL)

a. CONTRACTOR shall provide a toll-free 24/7 BAL to beneficiaries seeking access to Substance Use Disorder (SUD) services.

b. CONTRACTOR shall verify Medi-Cal eligibility for all requests for services.

c. CONTRACTOR's BAL shall provide oral and audio-logical (TTY/TDY) translations in the beneficiary's primary language.

d. The BAL shall provide 24/7 referrals to services for urgent conditions and medical emergencies.

1) CONTRACTOR shall initially screen beneficiaries over the phone to determine whether there is sufficient information to make a referral to the appropriate ASAM Level of Care (LOC) or whether a face-to-face ASAM assessment with the Health Care Agency, Behavioral Health Services (HCA BHS) is required to determine the beneficiary's appropriate LOC.

2) Beneficiaries screened as having an urgent need will be referred for an appointment with a qualified staff within 48 hours.

3) CONTRACTOR shall provide eligible, non-urgent beneficiaries a face-to-face appointment with the appropriate LOC provider within ten (10) business days from the initial service authorization request.

4) The BAL shall be staffed by registered certified counselors and Licensed Practitioner of the Healing Arts (LPHA).

e. CONTRACTOR's Point of Entry.

1) The CONTRACTOR shall ensure beneficiaries with non-urgent requests for services shall be referred for an ASAM with a DMC-ODS provider within ten (10) business days.

For beneficiaries scheduled for a face-to-face assessment, the BAL staff shall perform a biopsychosocial assessment to determine if the beneficiary meets medical necessity based on the current DSM and shall apply the ASAM criteria to make the appropriate LOC recommendation(s).

3. TIMELY ACCESS TO DRUG MEDI-CAL 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. Timely access for emergent calls does not apply to Drug Medi-Cal Services.

a. If the caller's needs are indicated as requiring 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. Urgent referrals for DMC shall be directed to the nearest ER.

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1) Emergent services shall be indicated when the Beneficiary 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 Beneficiary being a danger to himself/herself or others or an immediate inability of the Beneficiary to provide for, or utilize food, shelter or clothing as a result of a mental disorder. These calls must be linked within two (2) hours. Emergent services do not apply to DMC.

2) Urgent services shall be indicated when a situation experienced by a Beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. Beneficiaries 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 twenty-four (24) hours. For DMC, beneficiaries shall be referred to nearest ER or Detox Services.

3) CONTRACTOR must obtain confirmation that any caller assessed as requiring emergent or urgent care has been appropriately connected to COUNTY or police. Police intervention is not required for DMC. If the Beneficiary did not show up to the appointed session/evaluation, CONTRACTOR shall contact the Beneficiary 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. This does not apply to DMC.

b. If the caller's needs are indicated as requiring routine care, CONTRACTOR shall make a referral to a Network Provider for an appointment to be offered within ten (10) calendar days of the referral. Routine services shall be indicated when a Beneficiary's health needs are not urgent, but for whom health services of some type can improve functioning and/or reduce symptoms, or for whom 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 Beneficiary's 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. For DMC, clinicians shall be available to screen substance abuse needs and identify substance abuse medical concerns in callers.

d. Beneficiaries requesting health services shall not be denied services solely based upon a telephone clinical screening. Should it not be possible to determine a Beneficiary's needs, during the brief telephone clinical screening, CONTRACTOR shall take further steps to ensure beneficiaries are referred to the most appropriate level of care by referring the Beneficiary for a face-to-face assessment by an approved Network Provider. For DMC, beneficiaries will be referred to the nearest DMC ODS outpatient provider for a face to face screening.

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

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2) During the face-to-face assessment, psychological testing may be used to assist in the diagnostic evaluation process in cases where the clinical assessment alone is insufficient to determine appropriate diagnosis and treatment needs. This does not apply to DMC.

a) CONTRACTOR shall require that testing be provided only by licensed clinical psychologists. This does not necessarily apply to DMC.

b) Network Providers requesting psychological testing related to treatment decisions must submit a request, to CONTRACTOR, which shall be reviewed by CONTRACTOR. This does not apply to DMC.

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. This does not apply for beneficiaries seeking only DMC services.

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 Medical/Surgical hospital or in some cases in an ER shall be eligible for psychiatric consultation/treatment. Authorization and process shall be determined with ADMINISTRATOR. This does not apply to DMC.

2) Beneficiaries referred from COUNTY, no additional screening or assessment shall be required by CONTRACTOR. This does not apply to DMC.

3) Annual or semi-annual re-authorization through CONTRACTOR shall be required of Network Providers to continue these services for beneficiaries. This does not apply to DMC.

4) CONTRACTOR shall collaborate with physical health care providers to ensure the most appropriate level of medication management is provided. This does not apply to DMC.

c. Episodic Need for Services - Beneficiaries referred to CONTRACTOR's Network of Providers for services shall receive up to a total of six (6) treatment hours to include assessment. 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 six (6) initial hours authorized. Additional hours of service will require authorization by CONTRACTOR through an automated reauthorization process. This does not apply to DMC.

d. Out of COUNTY Services - CONTRACTOR shall be responsible for processing and paying claims for services provided to COUNTY Beneficiaries who meet medical necessity for

treatment and may require services while out of COUNTY as a result of urgent need or placement by COUNTY care coordinators and/or Social Services staff. This does not apply to DMC.

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 COUNTY. This does not apply to DMC

2) COUNTY will cooperate with the CONTRACTOR in connection with providing authorization for services to Beneficiaries 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 COUNTY at COUNTY's discretion, after notification to CONTRACTOR, at any point in the treatment. This does not apply to DMC.

e. Other Need for Services – Beneficiaries shall be referred to their MCP or PCP for treatment, if beneficiary'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 NOA-A, if applicable and, beyond assessment, are not the responsibility of COUNTY or CONTRACTOR. This does not apply to DMC.

f. Excluded Diagnosis – A Beneficiary's face-to-face assessment determines that the Beneficiary has an excluded diagnosis and therefore does not meet medical necessity criteria for receiving treatment from either COUNTY or CONTRACTOR, and a NOA-A shall be provided, if applicable. This does not apply to DMC

1) CONTRACTOR may have Network Providers who are capable of treating these Beneficiaries and can bill the State for these excluded diagnoses under the remaining FFS system. CONTRACTOR shall identify such providers within CONTRACTOR's network and shall make the appropriate referral in a timely manner. This does not apply to DMC.

2) CONTRACTOR may also refer these Beneficiaries to those community clinics not under contract with COUNTY to provide mental health services for these Beneficiaries. This does not apply to DMC.

5. COORDINATION WITH PHYSICAL HEALTH CARE – CONTRACTOR shall address the following issues in coordinating health needs: The coordination is with substance use and the PCP and/or the local MCP.

a. Timely coordination and referral.

b. Timely exchange of information.

c. Education of both Beneficiaries and DMC ODS Providers regarding system coordination.

d. Coordination of medications and laboratory services as they relate to the mental health and physical needs of the Beneficiary. Does not apply to DMC.

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1) A part of CONTRACTOR's PAR process shall include collecting and evaluating the Beneficiary's medication regimen. All medication monitoring forms shall be made available to the PCP's upon request. Does not apply to DMC

2) If CONTRACTOR's Access Line clinicians discover potential coordination of medication concerns between the treating psychiatrist and the PCP, telephone calls shall be placed to both providers to ensure appropriate coordination of care. Does not apply to DMC.

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 Beneficiaries 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 Beneficiary's PCP. Upon appropriate Beneficiary consent, Network Providers shall coordinate with the PCP regarding a patient concern. With proper Beneficiary consent, CONTRACTOR shall release the information from the Network Provider to the PCP to facilitate care coordination. This does not apply to DMC.

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

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8. Subparagraph IX. A. of Exhibit A to the Agreement is amended to read as follows:

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

ADMINISTRATION	FTEs
HR Representative	0.040
Project Manager	0.100
Accounting Manager	0.020
Tech. Ops	0.180
Application Developer	0.130
EDI Specialist	0.030
Data Base Developer/Analyst	0.004
SUBTOTAL ADMINISTRATION	0.504
PROGRAM	
Program Director	1.000
Clinical Manager	1.000
Clinical Lead	1.000
Drug Medi-Cal Lead	1.000
Utilization Review Clinician	5.000
Membership Service Representative/Care Coordinator I	6.000
Medical Director	0.260
ASO Network Manager	1.000
Claims Appeal Manager	0.150
Claims Data Specialist (Pooled Staff)	1.000
Credentialing Specialist (Pooled Staff)	0.300
Quality Improvement Coordinator	0.530
Care Coordinator II	3.000
After Hours Clinician (Pooled Staff)	0.750
Data Base Developer	0.250
Sr. Accountant	0.200
Data Base Administrator	0.500
SUBTOTAL PROGRAM	22.940
TOTAL FTEs	23.444"

In all other respects, the terms of the underlying Agreement, not specifically changed by this First Amendment, shall remain in full force and effect and are incorporated herein by this reference.

IN WITNESS WHEREOF, the parties have executed this Agreement, in the County of Orange, State of California.

BEACON HEALTH STRATEGIES, LLC

BY: DocuSigned by: Daniel Risku A4E61E3735E448E... DATED: 3/12/2018

TITLE: Executive Vice President & General Counsel

COUNTY OF ORANGE

BY: _____ DATED: _____

HEALTH CARE AGENCY

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

BY: DocuSigned by: Eric Devine C1E3086C1E6D4FD... DATED: 3/6/2018

DEPUTY

If the contracting party is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer. If the contract is signed by one (1) authorized individual only, a copy of the corporate resolution or by-laws whereby the board of directors has empowered said authorized individual to act on its behalf by his or her signature alone is required by ADMINISTRATOR.