

§ 1810.100. General Program Description.

Specialty mental health services, as defined in Section 1810.247 and in accordance with this Chapter, shall be provided to Medi-Cal beneficiaries of each county through a mental health plan which contracts with the Department to provide specialty mental health services to those Medi-Cal beneficiaries and to share in the financial risk of providing specialty mental health services as provided in this Chapter. When a mental health plan contracts with the Department pursuant to this Chapter, all beneficiaries of that county shall be eligible to receive Medi-Cal funded specialty mental health services as described in this Chapter only through the mental health plan. Medi-Cal funded services that are not the responsibility of the mental health plan may be obtained by beneficiaries under the provisions of Title 22, Division 3, Subdivision 1, beginning with Section 50000.

§ 1810.110. Applicability of Laws and Regulations and Program Flexibility.

(a) Each mental health plan contracting with the Department pursuant to this Chapter shall comply with this Chapter, all applicable federal laws, regulations and guidelines, and all applicable State laws and regulations, including Medi-Cal regulations in Division 3, Subdivision 1, of Title 22, beginning with Section 50000.

(b) Nothing in this Chapter supersedes federal or state laws or regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(c) Provisions of contracts between mental health plans and providers shall not be in conflict with this Chapter.

(d) The Department may waive specific requirements of the regulations in Subchapters 1, 2, 3, and 4 at the request of a mental health plan pursuant to Section 5719.5 of the Welfare and Institutions Code for the purpose of testing elements of the specialty mental health services delivery system as authorized by Section 5778(c) of the Welfare and Institutions Code, provided the mental health plan remains in compliance with all other applicable laws and regulations. A written request and substantiating evidence supporting the request shall be submitted by the mental health plan to the Department. If the request is consistent with this Subsection the Department, in consultation with the State Department of Health Services, pursuant to Section 5719.5 of the Welfare and Institutions Code, shall approve the request. The approval shall provide for the terms and conditions under which the exception is granted, and shall be effected by an amendment to the contract between the mental health plan and the Department under this Chapter.

§ 1810.200. Action.

“Action”, in the case of a mental health plan (MHP), means:

(a) A denial, modification, reduction or termination of a provider's request for MHP payment authorization of a specialty mental health service covered by the MHP.

(b) A determination by the MHP or its providers that the medical necessity criteria in Section 1830.205(b)(1), (b)(2), (b)(3)(C), or 1830.210(a) have not been met and the beneficiary is not entitled to any specialty mental health services from the MHP.

(c) A failure by the MHP to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP; or

(d) A failure by the MHP to act within the timeframes for resolution of grievances, appeals, or the expedited appeals established in Subchapter 5, Article 1.

§ 1810.201. Acute Psychiatric Inpatient Hospital Services.

“Acute Psychiatric Inpatient Hospital Services” means those services provided by a hospital to beneficiaries for whom the facilities, services and equipment described in Section 1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with Section 1820.205.

§ 1810.202. Administrative Day Service.

“Administrative Day Services” means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

§ 1810.203. Adult Residential Treatment Service.

“Adult Residential Treatment Service” means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

§ 1810.203.5. Appeal.

“Appeal” means:

(a) A request by a beneficiary or a beneficiary's representative for review of an action as defined in Section 1810.200;

(b) A request by a beneficiary or a beneficiary's representative for review of a provider's determination to deny or modify a beneficiary's request for a covered specialty mental health service;

(c) A request by a beneficiary or a beneficiary's representative for review of the timeliness of the delivery of a specialty mental health service when the beneficiary believes that services are not being delivered in time to meet the beneficiary's needs,

whether or not the mental health plan has established a timeliness standard for the delivery of the service.

(d) A request by an MHP and/or MHP subcontractor for review of client record review findings that resulted in the disallowance of paid claims.

§ 1810.204. Assessment.

“Assessment” means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

§ 1810.205. Beneficiary.

“Beneficiary” means any person certified as eligible under the Medi-Cal Program according to Title 22, Section 51000.2.

§ 1810.205.1. Border Community.

“Border Community” means a community located outside the State of California that is not considered to be out of state for the purpose of excluding coverage by the MHPs because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.

§ 1810.205.2. Client Plan.

“Client Plan” means a plan for the provision of specialty mental health services to an individual beneficiary who meets the medical necessity criteria in Sections 1830.205 or 1830.210.

§ 1810.206. Collateral.

“Collateral” means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

§ 1810.207. Contract Hospital.

“Contract Hospital” means a hospital that has a contract with a specific Mental Health Plan to provide psychiatric inpatient hospital services to beneficiaries.

§ 1810.207.5. County of Origin.

“County of Origin” means, for the purposes of out-of-plan Services under Section 1830.220, the county where legal jurisdiction has been established and/or that has financial responsibility for the child or youth. “County of Origin” is synonymous with the terms “County of Adjudication” and “County of Responsibility.”

§ 1810.208. Crisis Residential Treatment Service.

“Crisis Residential Treatment Service” means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

§ 1810.209. Crisis Intervention.

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.

§ 1810.210. Crisis Stabilization.

“Crisis Stabilization” means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.

§ 1810.211. Cultural Competence.

“Cultural Competence” means a set of congruent practice skills, behaviors, attitudes and policies in a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross cultural situations.

§ 1810.212. Day Rehabilitation.

“Day Rehabilitation” means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

§ 1810.213. Day Treatment Intensive.

“Day Treatment Intensive” means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

§ 1810.214. Department.

“Department” means the State Department of Mental Health.

§ 1810.214.1. Disproportionate Share Hospital (DSH).

“Disproportionate Share Hospital (DSH)” means a hospital that serves a disproportionate share of low-income people as determined annually by the State Department of Health Services in accordance with Section 14105.98 of the Welfare and Institutions Code.

§ 1810.215. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) S

“Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services” means mental health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by the State Department of Health Services to meet the criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered by this Chapter as specialty mental health services.

§ 1810.216. Emergency Psychiatric Condition.

“Emergency Psychiatric Condition” means a condition that meets the criteria in Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

§ 1810.216.1. Fair Hearing.

§ 1810.216.2. Expedited Appeal.

“Expedited Appeal” means an appeal as defined in Section 1810.203.5 to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal as established in Section 1850.207 would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

§ 1810.216.4. Expedited Fair Hearing.

“Expedited Fair Hearing” means a fair hearing as defined in Section 1810.216.6 to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that that following the timeframe for a fair hearing as established in Title

42, Code of Federal Regulations, Section 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

§ 1810.216.6. Fair Hearing.

“Fair Hearing” means the State hearing provided to beneficiaries pursuant to Title 22, Sections 50951 and 50953.

§ 1810.216.8. Federal Financial Participation (FFP).

“Federal Financial Participation (FFP)” means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

§ 1810.217. Fee-for-Service/Medi-Cal Hospital.

“Fee-for-Service/Medi-Cal Hospital” means a hospital that submits reimbursement claims for Medi-Cal psychiatric inpatient hospital services through the fiscal intermediary.

§ 1810.218. Fiscal Intermediary.

“Fiscal Intermediary” means the entity, which has contracted with the State Department of Health Services to perform services for the Medi-Cal Program pursuant to Section 14104.3 of the Welfare and Institutions Code.

§ 1810.218.1. Grievance.

“Grievance” means a beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an appeal as defined in Section 1810.203.5 filed through the MHP's grievance process as described in Sections 1850.205 and 1850.206 or a provider's grievance process if the MHP has delegated the process to a provider in accordance with Section 1850.209.

§ 1810.218.2. Group Provider.

“Group Provider” means an organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics.

§ 1810.219. Hospital.

“Hospital” means an institution that meets the requirements of Title 22, Section 51207, and has been certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services. Hospital includes general acute care hospitals as defined in Section 1250(a) of the Health and Safety Code, acute psychiatric hospitals as defined in Section 1250(b) of the Health and Safety Code, and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.

§ 1810.220. Hospital-Based Ancillary Services.

“Hospital-Based Ancillary Services” means services, which include but are not limited to prescription drugs, laboratory services, x-ray, electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a beneficiary admitted to a hospital, other than routine hospital services.

§ 1810.220.5. Host County.

“Host County” means the county where the child or youth is living when the child or youth is not living in the county of origin.

§ 1810.221. Implementation Plan.

“Implementation Plan” means a written description submitted to the Department by a prospective Mental Health Plan and approved by the Department that specifies the procedures that will be used by the Mental Health Plan to provide specialty mental health services to beneficiaries.

§ 1810.222. Individual Provider.

“Individual Provider” means licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.

§ 1810.222.1. Institution for Mental Diseases.

“Institution for Mental Diseases” means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disorders, including medical attention, nursing care, and related services.

§ 1810.223. Licensed Mental Health Professional.

“Licensed mental health professional” means licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.

§ 1810.223.5. Medi-Cal Eligibility Data System (MEDS).

“Medi-Cal Eligibility Data System (MEDS)” means the data system maintained by the State Department of Health Services that contains information on Medi-Cal eligibility including a beneficiary's county of responsibility.

§ 1810.224. Medi-Cal Managed Care Plan.

“Medi-Cal Managed Care Plan” means an entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries under Chapter 7,

commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3 of the Welfare and Institutions Code.

§ 1810.225. Medication Support Services.

“Medication Support Services” means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.

§ 1810.225.1. Memorandum of Understanding (MOU).

“Memorandum of Understanding (MOU)” means a written agreement between mental health plans and Medi-Cal managed care plans describing their responsibilities in the delivery of specialty mental health services to beneficiaries who are served by both parties.

§ 1810.226. Mental Health Plan (MHP).

“Mental Health Plan” (MHP) means an entity that enters into a contract with the Department to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county as provided in this Chapter. An MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

§ 1810.227. Mental Health Services.

“Mental Health Services” means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

§ 1810.228. MHP of Beneficiary.

“MHP of beneficiary” means the MHP responsible for providing or arranging and paying for specialty mental health services for a beneficiary under the provisions of this Chapter. The responsible MHP is the MHP serving the county that corresponds to the beneficiary's county of responsibility code as listed in the Medi-Cal Eligibility Data System (MEDS), unless another MHP is determined responsible pursuant to Section 1850.405.

§ 1810.229. MHP Payment Authorization.

“MHP Payment Authorization” means the written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary.

§ 1810.230. Non-Contract Hospital.

“Non-contract Hospital” means a hospital which is certified by the State Department of Health Services to provide Medi-Cal services, but which does not have a contract with a specific MHP to provide psychiatric inpatient hospital services to beneficiaries.

§ 1810.230.5. Notice of Action.

“Notice of Action” means a written notice from the MHP to a beneficiary when an MHP takes an action as defined in Section 1810.200(a), (c) or (d) or when an MHP or its providers take an action as defined in Section 1810.200(b).

§ 1810.231. Organizational Provider.

“Organizational provider” means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waived/registered professionals and other staff. The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.

§ 1810.231.1. Physical Health Care or Physical Health Care Based Treatment.

“Physical Health Care” and “Physical Health Care Based Treatment” mean health care services provided by health professionals, including physicians, whose practice is predominately general medicine, family practice, internal medicine, pediatrics, obstetrics or gynecology, or whose practice is predominately a health care specialty area other than psychiatry or psychology. Physical health care does not include:

(a) A physician service as described in Title 22, Section 51305, delivered by a psychiatrist. A psychiatrist for the purpose of this definition is a physician who has not indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program.

(b) A psychologist service as described in Title 22, Section 51309.

(c) An EPSDT supplemental service as described in Title 22, Sections 51340 or 51340.1, delivered by a licensed clinical social worker, a licensed marriage and family therapist to treat a mental illness or condition.

§ 1810.232. Plan Development.

“Plan Development” means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.

§ 1810.233. Point of Authorization.

“Point of Authorization” means the function within the MHP that is required to receive provider communications 24 hours a day, seven days a week regarding requests for MHP payment authorization of psychiatric inpatient hospital, psychiatric health facility, and psychiatric nursing facility services and authorizes payment for those services. This function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization functions.

§ 1810.234. Prior Authorization.

“Prior authorization” means the issuance of an MHP payment authorization to a provider before the requested service has been provided.

§ 1810.235. Provider.

“Provider” means person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in this Chapter and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the MHP.

§ 1810.236. Psychiatric Health Facility.

“Psychiatric Health Facility” means a facility licensed by the Department under the provisions of Chapter 9, Division 5 of Title 22, beginning with Section 77001. For the purposes of this Chapter, psychiatric health facilities that have been certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services will be governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.

§ 1810.237. Psychiatric Health Facility Services.

“Psychiatric Health Facility Services” means therapeutic and/or rehabilitative services provided in a psychiatric health facility, other than a psychiatric health facility that has been certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services, on an inpatient basis to beneficiaries who need acute care, which is care that meets the criteria of Section 1820.205, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings.

§ 1810.237.1. Psychiatric Inpatient Hospital Professional Services.

“Psychiatric Inpatient Hospital Professional Services” means specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for

psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

§ 1810.238. Psychiatric Inpatient Hospital Services.

“Psychiatric Inpatient Hospital Services” means both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.

§ 1810.239. Psychiatric Nursing Facility Services.

“Psychiatric Nursing Facility Services” means skilled nursing facility services as defined in Title 22, Section 51123, that include special treatment program services for mentally disordered persons as defined in Title 22, Section 72443, provided by an entity that is licensed as a skilled nursing facility by the State Department of Health Services and is certified by the Department to provide special treatment program services.

§ 1810.240. Psychiatrist Services.

“Psychiatrist Services” means services provided by licensed physicians, within their scope of practice, who have contracted with the MHP to provide specialty mental health services, who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program, to diagnose or treat a mental illness or condition. For the purposes of this Chapter, psychiatrist services may only be provided by physicians who are individual or group providers.

§ 1810.241. Psychologist Services.

“Psychologist Services” means services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition. For the purposes of this Chapter, psychologist services may only be provided by licensed psychologists who are individual or group providers.

§ 1810.242. Receipt or Date of Receipt.

“Receipt” means the receipt of a Treatment Authorization Request or other document. The “date of receipt” means the date the document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver.

§ 1810.243. Rehabilitation.

“Rehabilitation” means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

§ 1810.243.1. Rehabilitative Mental Health Services.

“Rehabilitative Mental Health Services” means those services included in Section 1810.247(a) and separately defined in this Article.

§ 1810.243.5. Risk Reinsurance.

“Risk Reinsurance” means an insurance policy purchased for an MHP that provides coverage for costs of providing services exceeding specified limits.

§ 1810.244. Routine Hospital Services.

“Routine Hospital Services” means bed, board and all medical, nursing and other support services usually provided to an inpatient by a hospital. Routine hospital services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

§ 1810.245. Service Activities.

“Service Activities” means activities conducted to provide specialty mental health services when the definition of the service includes these activities. Service activities include, but are not limited to, assessment, collateral, therapy, rehabilitation, and plan development.

§ 1810.246. Short-Doyle/Medi-Cal Hospital.

“Short-Doyle/Medi-Cal Hospital” means a hospital that submits claims for Medi-Cal psychiatric inpatient hospital services through the Department to the State Department of Health Services and not to the fiscal intermediary.

§ 1810.246.1. Significant Support Person.

“Significant support person” means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

§ 1810.246.2. Small County.

“Small County” means a county in California with a population of less than 200,000 as determined by 1990 census data.

§ 1810.246.3. Small County Reserve.

“Small County Reserve” means that portion of the State General Fund appropriation for consolidation of psychiatric inpatient hospital services that is allocated for use by MHPs in small counties as self-insurance to provide a mechanism to reduce financial risk.

§ 1810.247. Specialty Mental Health Services.

“Specialty Mental Health Services” means:

(a) Rehabilitative Mental Health Services, including:

- (1) Mental health services;
- (2) Medication support services;
- (3) Day treatment intensive;
- (4) Day rehabilitation;
- (5) Crisis intervention;
- (6) Crisis stabilization;
- (7) Adult residential treatment services;
- (8) Crisis residential treatment services;
- (9) Psychiatric health facility services;
- (b) Psychiatric Inpatient Hospital Services;
- (c) Targeted Case Management;
- (d) Psychiatrist Services;
- (e) Psychologist Services;
- (f) EPSDT Supplemental Specialty Mental Health Services; and
- (g) Psychiatric Nursing Facility Services.

§ 1810.248. Submit or Date of Submission.

“Submit” means to transmit a document by mail, fax, or hand delivery. The “date of submission” means the date the document was submitted as indicated by the postmark date, the fax date, or the date of hand delivery as shown by a date stamp made by the receiver. For documents submitted by mail, the postmark date shall be used as the date of submission.

§ 1810.249. Targeted Case Management.

“Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

§ 1810.250. Therapy.

“Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

§ 1810.251. Third Party Liability.

“Third Party Liability” means an amount owed for specialty mental health services on behalf of a beneficiary by any payer other than the MHP, the Medi-Cal program or the beneficiary.

§ 1810.252. Traditional Hospital.

“Traditional Hospital” means a Fee-for-Service/Medi-Cal hospital that, according to historical Medi-Cal payment data collected by the State Department of Health Services for the most recent fiscal year, provides services to beneficiaries of an MHP that account for five percent or twenty thousand dollars, whichever is more, of the total fiscal year Medi-Cal psychiatric inpatient hospital service payments made to Fee-for-Service/Medi-Cal hospitals for beneficiaries of an MHP.

§ 1810.253. Urgent Condition.

“Urgent Condition” means a situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.

§ 1810.253.1. Usual and Customary Charges.

“Usual and Customary Charges” means those uniform charges that are listed in a provider's established charge schedule which are in effect and applied consistently to most patients.

§ 1810.254. Waivered/Registered Professional.

“Waivered/Registered Professional” means an individual who has a waiver of psychologist licensure issued by the Department or has registered with the corresponding state licensing authority for psychologists, marriage and family therapists or clinical social workers to obtain supervised clinical hours for psychologist, marriage and family therapist or clinical social worker licensure.

§ 1810.305. Designation of MHPs.

(a) A county that wishes to be designated by the Department as the MHP for the beneficiaries of that county shall communicate its intent in a resolution from the county board of supervisors, which shall be transmitted, to the Department. The resolution shall state that:

(1) The county is willing to assume responsibility for Medi-Cal authorization and payment for all covered specialty mental health services for beneficiaries of that MHP and assures that access to services through the MHP will be no less than access provided to beneficiaries prior to operation of the MHP.

(2) The county recognizes and agrees that the allocation of State funds pursuant to Section 5778 of the Welfare and Institutions Code, will be the full payment from the State for the services specified in Subsection (a)(1), except as specifically provided in this Chapter or in the contract between the county and the Department under this Chapter.

(3) The county will utilize a public planning process that involves various constituency groups, including, but not limited to beneficiaries, providers, and beneficiaries' significant support persons as self identified, to assist in formulating policies and procedures for the operation of the MHP insofar as these policies and procedures are not specifically prescribed in law and regulation.

(4) The county will submit to the Department an Implementation Plan pursuant to Section 1810.310.

(b) The Department may designate other qualifying entities including another county, other counties acting jointly, or other governmental and non-governmental entities, to be the MHP pursuant to Section 5775 of the Welfare and Institutions Code under any of the following conditions:

(1) A county declines to be the MHP for the beneficiaries of that county.

(2) The county or the Department terminates or fails to renew the contract between the Department and a county originally designated to be the MHP.

(3) The county fails to utilize a public planning process pursuant to Subsection (a)(3).

(4) The county fails to submit an Implementation Plan to the Department pursuant to Section 1810.310.

(5) The Implementation Plan submitted by the county pursuant to Section 1810.310 is disapproved by the Department.

(c) The entity selected under Subsection (b) shall meet the same duties and obligations required of a county in Subsections (a)(1)-(4).

(d) The Department may designate an entity to be an MHP pursuant to Subsection (b) through a competitive procurement process. If the Department elects to do so, the Department may integrate the requirements of Subsections (a)(1)-(4) and the requirements of Section 1810.310 into the procurement process.

§ 1810.310. Implementation Plan.

(a) An entity designated to be an MHP shall submit an Implementation Plan to the Department, within the time frame established by the Department. The time frame shall be no more than 180 days and no less than 90 calendar days prior to the date on which the entity proposes to begin operations. The Implementation Plan shall include:

(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.

(2) A description of the process for:

(A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.

(B) Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.

(C) Assuring continuity of care for beneficiaries receiving specialty mental health services prior to the date the entity begins operation as the MHP.

(D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.

(3) A description of the processes for problem resolution as required in Subchapter 5.

(4) A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435. The entity designated to be the MHP shall include a Request for Exemption from Contracting in accordance with Section 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH.

(5) Documentation that demonstrates that the entity:

(A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries that will be served by the MHP, and

(B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served by the MHP.

(6) A description of how the MHP will deliver age-appropriate services to beneficiaries.

(7) The proposed Cultural Competence Plan as described in Section 1810.410, unless the Department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the Department pursuant to Section 1810.410(c).

(8) A description of a process for planned admissions in non-contract hospitals if such an admission is determined to be necessary by the MHP.

(9) A description of the MHP's Quality Improvement and Utilization Management Programs.

(10) A description of policies and procedures that assure beneficiary confidentiality in compliance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in this Chapter.

(b) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to applicant MHP entities within 60 calendar days of the receipt of the Implementation Plan.

(c) An MHP shall submit proposed changes to its approved Implementation Plan in writing to the Department for review.

(1) An MHP shall submit proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan prior to implementing the proposed changes.

(2) An MHP shall submit documentation establishing its continued capacity to meet the Implementation Plan requirements of Subsection (a)(5) whenever there is a change in the MHP's operation that would require a change in services or providers by 25 percent or more of the beneficiaries who are receiving services from the MHP or a reduction of an average of 25 percent or more in provider rates for providers of outpatient mental health services that paid on a fee-for-service basis.

(3) If the changes are consistent with this Chapter, the changes shall be approved by the Department.

(4) The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within 30 calendar days after the receipt of the notice from the MHP.

(5) The MHP may implement the proposed changes 30 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

§ 1810.315. Contracts Between the Department and the MHP.

Upon approval of an Implementation Plan pursuant to Section 1810.310, the entity designated pursuant to Section 1810.305 shall enter into a contract with the Department. There is no obligation to pay by the Department absent an executed contract with the MHP, incorporating these regulations as terms of the contract.

§ 1810.317. Contract Term.

(a) The term of the contract between an MHP and the Department shall be for a term agreed to by the parties. Regardless of the effective date of the contract, the expiration date of the contract shall be June 30, the end of the State fiscal year.

(b) Prior to the expiration of this contract and upon request by the Department, the MHP shall assist the State in the orderly transfer of beneficiaries' mental health care. In doing this, the MHP shall make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction shall be borne by the Department. In no circumstances shall a beneficiary be billed for this service.

§ 1810.319. Contract Amendment.

The contract may be amended by mutual written agreement of the MHP and the Department.

§ 1810.320. Contract Renewal. [Repealed]

§ 1810.321. Contract Renewal.

(a) The Department may, in its sole discretion renew an MHP contract.

(b) If the MHP chooses non-renewal of the contract, then the MHP shall give the Department at least 180 calendar days prior notice of non-renewal.

(c) If the Department chooses non-renewal of the contract, the Department shall give the MHP at least 180 calendar days prior notice of non-renewal, unless the Department determines that the MHP has not complied with the requirements of law or regulation or terms of the contract, in which case the Department must give at least 90 days prior notice of non-renewal.

(d) Prior to the nonrenewal of this contract and upon request by the Department, the MHP shall assist the State in the orderly transfer of beneficiaries' mental health care. In doing this, the MHP shall make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction shall be borne by the Department. In no circumstance shall a beneficiary be billed for this service.

§ 1810.323. Contract Termination.

(a) The MHP may terminate its contract with the Department in accordance with the terms of its contract with the Department by delivering written notice of termination to the Department at least 180 calendar days prior to the effective date of termination.

(b) The Department shall immediately terminate its contract with an MHP if the Department finds that there is an immediate and significant threat to the health and safety of Medi-Cal beneficiaries as a result of action or inaction by the MHP.

(c) The Department shall terminate its contract with an MHP that the Secretary, Health and Human Services has determined does not meet the requirements for participation in the Medicaid program as provided in Title XIX of the Social Security Act. The Department shall deliver written notice of termination to the MHP at least 60 calendar days prior to the effective date of termination.

(d) The Department may terminate the MHP contract for noncompliance with the requirements of law or regulations or terms of the contract. The Department shall deliver written notice of termination to the MHP at least 90 calendar days prior to the effective date of termination.

(e) The Department may terminate its contract with an MHP for any reason not specified in Subsections (b), (c), or (d) by delivering written notice of termination to the MHP at least 180 calendar days prior to the effective date of termination.

(f) The Department may terminate its contract with an MHP if the Department determines that the contract is no longer in the best interests of the State.

(g) The written notice of termination shall be provided to the MHP and to other persons and organizations as the Department may deem necessary.

(h) The written notice of termination shall include the reason for the termination and the effective date of termination.

(i) In the event that the contract with an MHP is terminated for any cause, the remaining balance of State funds that were transferred to the MHP for specialty mental health services pursuant to Section 1810.330 shall be returned to the Department on a timeline specified by the Department in the notice of termination. The Department has a right to examine all records of an MHP to determine the balance of funds to be returned to the Department.

(j) Prior to the termination of this contract and upon request by the Department, the MHP shall assist the State in the orderly transfer of beneficiaries' mental health care. In doing this, the MHP shall make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction shall be borne by the Department. In no circumstance shall a beneficiary be billed for this service.

§ 1810.325. Appeal of Contract Termination.

(a) The MHP may appeal, in writing, a contract termination to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department shall grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the Department may take another action available under Section 1810.380(b). The Department's election to take another action shall not be appealed to the Department. Except for terminations pursuant to Section 1810.323(b), the Department shall suspend the termination date until the Department has acted on the MHP's appeal.

(b) The MHP may request that a public hearing be held by the Office of Administrative Hearings to allow the Department to show cause for the termination. The public hearing shall be held no later than 30 calendar days after receipt by the MHP of the notice to terminate the contract. In order to give the Office of Administrative Hearings sufficient time to arrange for a hearing, the MHP request for a hearing shall be submitted no later than five working days after receipt of the notice to terminate, by making its request to the Office of Administrative Hearings directly. The MHP shall have no right to a hearing before the Office of Administrative Hearings, unless the request has been submitted no later than five working days after receipt of the notice to terminate.

(c) The Office of Administrative Hearings shall provide written recommendations concerning the termination of the contract to the Department and to the MHP within 30

calendar days after conclusion of the hearing. The Department shall act to grant or deny the appeal within 30 calendar days after receipt of the recommendations of the Office of Administrative Hearings. In granting an appeal, the Department may take another action available under Section 1810.380(b). The Department's election to take another action shall not be appealable to the Department or to the Office of Administrative Hearings. Except for terminations pursuant to Section 1810.323(b), the Department shall suspend the termination date until the Department has acted on the MHP's appeal.

§ 1810.326. Practice Guidelines.

The MHP shall comply with title 42 Code of Federal Regulations (CFR) section 438.236. This regulation implements, interprets and makes specific state statute sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.330. Allocation of State Funds to MHPs.

In consultation with a statewide organization representing counties, the Department shall determine the methodology for allocating state funds to the MHPs annually. The methodology shall include a determination of the level for the Small County Reserve allocation as provided in Section 5778(j)(2)(A) and (k) of the Welfare and Institutions Code. The allocation shall include state funds for specialty mental health services covered by the MHP pursuant to Section 1810.345 that are not eligible for federal financial participation pursuant to Subchapter 4, subject to the appropriation of such funds by the legislature. State funds based on the allocation process shall be provided to each MHP annually in accordance with the terms of its contract with the Department and to the Small County Reserve as provided in Section 5778(j)(2)(A) and (k) of the Welfare and Institutions Code.

§ 1810.335. Renegotiation of the Allocation of State Funds to an MHP.

Either the Department or an MHP may request renegotiation of the amount of state funds paid to the MHP for the fiscal year, if it determines that there have been changes in the obligations of the MHP as a result of changes in federal or state law or regulation or the interpretation or implementation of federal or state law or regulation that increases or decreases the cost of providing services under the contract between the Department and the MHP after the annual allocation of state funds has been determined in accordance with Section 1810.330. Any change in the amount of state funds to be paid to the MHP agreed to by the parties shall be effected as an amendment to the contract between the Department and the MHP and shall be effective as of the date the obligations changed or a date agreed to by the parties, whichever is later. Any changes in state funding shall be subject to appropriation by the legislature.

§ 1810.341. Small County Reserve Allocation.

(a) MHPs in small counties shall establish the Small County Reserve with funds allocated by the Department pursuant to Section 1810.330.

(b) The Small County Reserve may only be used for:

(1) Reimbursement of MHPs in small counties for the cost of psychiatric inpatient hospital services in excess of their allocation.

(2) Purchase of risk reinsurance for MHPs in small counties.

(3) Alternatives to hospitalization as determined by the MHPs in small counties.

(4) Costs associated with the administration of the Reserve.

(c) Any interest earned from funds held in the Small County Reserve shall accrue to the Small County Reserve.

(d) The Department shall not be liable for obligations of the MHPs in small counties that exceed the balance in the Small County Reserve. When costs do not exceed the balance in the Small County Reserve during any given State fiscal year, the amount of unexpended funds shall be reported to the Department by November 30 of the following State fiscal year. The unexpended funds may be retained in the Small County Reserve and used as specified in Subsection (b).

(e) The MHPs in the small counties shall establish a Utilization Control and Operations Committee. The administrative procedures for, and the process of, appointing members to the Utilization Control and Operations Committee of the Small County Reserve shall be determined by the MHPs in small counties, through an organization representing the MHPs, in consultation with the Department. The Department shall not be liable for any action of the MHPs in small counties or the Utilization Control and Operations Committee related to the administration of the Small County Reserve.

(f) The Utilization Control and Operations Committee shall:

(1) Develop procedures and provide policy direction for the operation of the Small County Reserve.

(2) Determine circumstances under which a small county MHP shall be eligible to receive Small County Reserve funds.

(3) Provide guidance for the day-to-day operation of the Small County Reserve.

(4) Monitor utilization of psychiatric inpatient hospital services and other specialty mental health services by member MHPs.

(5) Recommend corrective actions and arrange for technical assistance to MHPs that have been denied access to the Small County Reserve funds.

§ 1810.345. Scope of Covered Specialty Mental Health Services.

(a) The MHP of a beneficiary shall provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. The MHP of a beneficiary shall be required to provide specialty mental health services only to beneficiaries who:

(1) Are eligible to receive Medi-Cal funded services in a Medi-Cal program under Title 22, Division 3, Subdivision 1, Chapter 2, Article 5, Section 50201 et seq., or Article 7, Section 50301 et seq., which includes the provision of specialty mental health services, and only to the extent the specific specialty mental health services are included in that Medi-Cal program, and

(2) Have met their share of cost obligations under Title 22, Sections 50651-50659.

(b) Except as provided elsewhere in this Chapter, the MHP shall not be required to establish a formal arrangement within the MHP's organization or through contracts with providers for any specific specialty mental health service, but shall ensure that the type or types of specialty mental health services provided to each individual beneficiary are adequate to meet the needs of the beneficiary as described in the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210.

(c) When appropriate based on the mental health condition of the beneficiary, the MHP of a beneficiary shall ensure that covered specialty mental health services described in Section 1810.247(a) are directed toward the maximum reduction of the mental disability and restoration of the beneficiary to the best possible functional level to the extent required by the Medi-Cal State Plan under rehabilitative mental health services. The Medi-Cal State Plan is California's State plan for medical assistance as described in Title 42, Section 1396 and 1396a, United States Code.

(d) In accordance with title 42 CFR section 438.210(a)(3)-(4), the MHP may place appropriate limits on a service.

(e) Notwithstanding section 1830.220 regarding out-of-plan services, the MHP is financially responsible for post-stabilization care services obtained within or outside of the MHP's provider network that are provided in compliance with title 42 CFR section 422.113(c)(1)-(3).

(f) The MHP shall obtain prior approval from the Department if the MHP intends to refuse to provide or arrange and pay for a covered service because the MHP objects to the service on moral or religious grounds.

(1) The Department shall approve the request only if the State is able to provide adequate access to the service or services the MHP does not intend to provide.

(2) If the Department does not approve the request, the MHP may terminate the contract in accordance with section 1810.323.

(g) The Department may exclude psychiatric nursing facility services from the specialty mental health services covered by the MHP until the Department determines that all necessary systems are in place at the State level to ensure proper payment of the providers of psychiatric nursing facility services and proper claiming of federal funds pursuant to Subchapter 4, beginning with Section 1840.100. The Department shall insure that the contract between the MHP and the Department and the allocation to the MHP pursuant to Section 1810.330 reflect the exclusion or inclusion of these services.

§ 1810.350. Scope of Covered Psychiatric Inpatient Hospital Services.

(a) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services as described in Subsections (b) and (c) and Section 1810.345.

(b) Psychiatric Inpatient Hospital Services for a Fee-for-Service/Medi-Cal hospital shall include:

- (1) Routine hospital services and
- (2) All hospital-based ancillary services.

(c) Psychiatric Inpatient Hospital Services for a Short-Doyle/Medi-Cal hospital shall include:

- (1) Routine hospital services,
- (2) All hospital-based ancillary services, and
- (3) Psychiatric inpatient hospital professional services.

(d) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services provided to a beneficiary eligible for Medicare (Part A) if the payment being authorized is for administrative day services following any approved acute psychiatric inpatient hospital services day and there is compliance with Section 1820.220(j)(5).

(e) The MHP shall obtain prior approval from the Department if the MHP intends to refuse to provide or arrange and pay for a covered service because the MHP objects to the service on moral or religious grounds.

- (1) The Department shall approve the request only if the State is able to provide adequate access to the service or services that the MHP does not intend to provide.
- (2) If the Department does not approve the request, the MHP may terminate the contract in accordance with section 1810.323.

§ 1810.355. Excluded Services.

MHPs shall not be responsible to provide or arrange and pay for the following services:

(a) Medi-Cal services, which are those services described in Title 22, Division 3, Subdivision 1, Chapter 3, Section 51001 et seq., that are not specialty mental health services for which the MHP is responsible pursuant to Section 1810.345.

(1) Prescribed drugs as described in Title 22, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, Section 51311, are not the responsibility of the MHPs, except when provided as hospital-based ancillary services. Medi-Cal beneficiaries may obtain Medi-Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with

the MHP under provisions of Title 22, Division 3, Subdivision 1, beginning with Section 50000.

(2) Medical transportation services as described in Title 22, Section 51323, are not the responsibility of the MHP, except when the purpose of the medical transportation service is to transport a beneficiary receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24 hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

(3) Physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205, are not the responsibility of the MHP.

(4) Personal care services as defined in Title 22, Section 51183, and as defined by the State Department of Health Services as EPSDT supplemental services pursuant to Title 22, Section 51340(e)(3) are not the responsibility of the MHP.

(b) Out-of-state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

(c) Specialty mental health services provided by a hospital operated by the Department or the State Department of Developmental Services.

(d) Specialty mental health services provided to a beneficiary eligible for Medicare prior to the exhaustion of beneficiary's Medicare mental health benefits, unless the services have been denied by Medicare. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRGs), when the DRG reimbursement covers administrative day services according to Medicare (Part A).

(e) Specialty mental health services provided to a beneficiary enrolled in a Medi-Cal Managed Care Plan to the extent specialty mental health services are covered by the Medi-Cal Managed Care Plan.

(f) Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a).

(g) Medi-Cal services that may include specialty mental health services as a component of a larger service package as follows:

(1) Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, Section 54325.

(2) Home and community based waiver services as defined in Title 22, Section 51176.

(3) Psychiatrist services, psychologist services, and EPSDT supplemental specialty mental health services payable by the Medi-Cal fiscal intermediary that are authorized

by the California Children's Services (CCS) Program to treat CCS eligible beneficiaries or the Genetically Handicapped Persons Program (GHPP) to treat GHPP eligible beneficiaries.

(4) Local Education Agency (LEA) services as defined in Title 22, Section 51190.4.

(5) Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.

(6) Home health agency services as described in Title 22, Section 51337.

§ 1810.360. Notification of Beneficiaries.

(a) The MHP shall develop, implement and maintain written policies that address the beneficiary's rights in accordance with title 42 CFR section 438.100 and shall communicate these policies to its beneficiaries and providers.

(b) Prior to the date the MHP begins operation, the Department shall mail a notice to all beneficiaries in a county containing the following information:

(1) The date the MHP will begin operation.

(2) The name and statewide, toll-free telephone number of the MHP.

(3) The availability of a booklet and provider list that contain the information required by Title 42, Code of Federal Regulations, Section 438.10(f)(6) and (g).

(4) The availability of problem resolution processes, including fair hearings.

(c) The Department shall provide beneficiaries who become eligible for Medi-Cal after the notice described in Subsection (a) is mailed with a notice containing the information listed in Subsections (a)(2)-(4) either through the mail or through the Medi-Cal eligibility determination process.

(d) The Department shall provide an annual written notice to all Medi-Cal beneficiaries informing them of their right to request and obtain a booklet and provider list from the MHP that contain the information required by Title 42, Code of Federal Regulations, Section 438.10(f)(6) and (g).

(e) The MHP of the beneficiary shall provide its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service from the MHP or its contract providers. This responsibility applies to the beneficiary's receipt of any specialty mental health service, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Section 1830.205 are met.

(f) The booklet and provider list shall be updated as required by the contract between the Department and the MHP. Pursuant to Title 42, Code of Federal Regulations, Section 438.10(f)(4), when there is a change in the scope of specialty mental health services covered by the MHP, an update in the form of a booklet insert shall be provided to beneficiaries at least 30 days prior to the change.

(g) The booklet shall be updated to reflect changes in State laws governing advance directives as soon as possible, but no later than 90 days after the effective date of the change. The MHP shall maintain written policies and procedures respecting advance directives in compliance with the requirements of title 42 CFR sections 422.128 and 438.6(i)(1), (3) and (4).

(h) The MHP shall provide written notice to beneficiaries in regards to the termination of a provider's contract as required by title 42 CFR section 438.10(f)(5).

§ 1810.365. Beneficiary Billing.

(a) The MHP of a beneficiary, or an affiliate, vendor, contractor, or sub-subcontractor of the MHP shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health services provided under this Chapter or related administrative services such as billing for missed appointments or making copies of client records, except to collect:

(1) Other health care coverage pursuant to Title 22, Section 51005.

(2) Share of cost as provided in Title 22, Sections 50657 through 50659.

(3) Copayments in accordance with Section 14134 of the Welfare and Institutions Code and Title 22, Section 51004.

(b) In the event that a beneficiary willfully refuses to provide other current health insurance coverage billing information, as described in Title 22, Section 50763(a)(5), to a provider, including the MHP, upon giving the beneficiary written notice of intent, the provider may bill the beneficiary as a private pay patient.

(c) The MHP or an affiliate, vendor, contractor, or sub-contractor of the MHP shall not hold beneficiaries liable for debts in the event that:

(1) the MHP becomes insolvent,

(2) the State does not pay the MHP for costs of covered services.

(3) the State or the MHP does not pay the MHP provider(s) for covered services.

(4) covered services are provided and paid for under a contract, referral or other arrangement rather than from the MHP,

(5) subsequent screening and treatment is needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

§ 1810.370. MOUs with Medi-Cal Managed Care Plans.

(a) The MHP shall enter into an MOU with any Medi-Cal Managed Care Plan that enrolls beneficiaries covered by the MHP. The MOU shall, at a minimum, address the following:

(1) Referral protocols between plans, including:

(A) How the MHP will provide a referral to the Medi-Cal managed care plan when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment and

(B) How the Medi-Cal managed care plan will provide a referral when the Medi-Cal managed care plan determines specialty mental health services covered by the MHP may be required.

(2) The availability of clinical consultation, including consultation on medications, to the Medi-Cal managed care plan for beneficiaries whose mental illness is being treated by the Medi-Cal managed care plan.

(3) Management of a beneficiary's care, including procedures for the exchange of medical information. The procedures shall ensure that the confidentiality of medical records is maintained in accordance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(4) Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP when those necessary services are covered by the Medi-Cal managed care plan. The procedures shall address, but are not limited to:

(A) Prescription drugs and laboratory services covered by the Medi-Cal managed care plan and prescribed through the MHP. Prescription drug and laboratory service procedures shall include:

1. The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Medi-Cal managed care plan, if the Medi-Cal managed care plan covers prescription drugs.
2. The Medi-Cal managed care plan's obligation to provide the Medi-Cal managed care plan's procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP, if the Medi-Cal managed care plan covers these services.
3. The MHP's obligation to designate a process or entity to receive notices of actions, denials, or deferrals from the Medi-Cal managed care plan and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination by the Medi-Cal managed care plan.
4. The MHP's obligation to respond by the close of the business day following the day the deferral notice is received by the MHP.

(B) Emergency room facility and related services other than specialty mental health services, home health agency services as described in Title 22, Section 51337, non-emergency medical transportation, and services to treat the physical health care needs of beneficiaries who are receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

(C) Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's medical problems based on changes in the beneficiary' mental health or medical condition.

(5) A process for resolving disputes between the MHP and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services and prescription drugs, while the dispute is being resolved. When the dispute involves the Medi-Cal managed care plan continuing to provide services to a beneficiary the Medi-Cal managed care plan believes requires specialty mental health services from the MHP, the MHP shall identify and provide the Medi-Cal managed care plan with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi-Cal managed care plan provider responsible for the beneficiary's care.

(b) If the MHP does not enter into an MOU with the Medi-Cal managed care plan, the MHP shall not be out of compliance with this Section provided the MHP establishes to the satisfaction of the Department that it has made good faith efforts to enter into an MOU.

§ 1810.375. MHP Reporting.

Each MHP shall submit reports to the Department as specified below.

(a) A report that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition.

(b) A list of all hospitals with which the MHP has current contracts, submitted by October 1 of each year.

(c) Fee-for-Service/Medi-Cal contract hospital rates negotiated by the MHP for each State fiscal year, submitted June 1 prior to the beginning of each State fiscal year.

(d) Pursuant to Welfare and Institutions Code section 5777(a)(1), by December 31 of the year following the close of each State fiscal year, the amount of any unexpended balance for the cost of covered services, utilization review and administration still remaining from the allocation made pursuant to Sections 1810.330 or 1810.335 for that State fiscal year. This reporting requirement shall also apply to the organizational entity administering the small county reserve pursuant to Section 1810.341(e). Neither an MHP nor the organizational entity administering the small county reserve shall be required to return any excess to the Department.

(e) Any reports required in the contract between the Department and the MHP.

§ 1810.376. Health Information Systems.

(a) The MHP shall maintain a health information system that collects, analyzes, integrates, and reports data and provides information on areas including, but not limited to, utilization, grievances and appeals as required by title 42 CFR section 438.242(a).

(b) The basic elements of the health information system as required by title 42 CFR section 438.242(b) shall, at a minimum:

(1) collect data on a beneficiary and provider and on services furnished to beneficiaries;

(2) ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.

(c) Nothing in this section requires that all elements of the MHP's health information system be collected and analyzed in electronic formats.

(d) For the purpose of this section, "persons with special health care needs" are adults with a serious mental disorder and children with a serious emotional disturbance as defined under Welfare and Institutions Code Section 5600.3.

§ 1810.380. State Oversight.

(a) The MHPs shall be subject to state oversight, including the following:

(1) Site visits and monitoring of data reports from MHPs and claims processing.

(2) Reviews of program and fiscal operations and the books and records of each MHP to verify that medically necessary services are provided in compliance with this Chapter and the contract between the Department and the MHP.

(A) These books and records shall disclose the quantity of covered services provided under this contract, the quality of those services, the manner and amount of payment made for those services, the beneficiaries eligible to receive covered services, the manner in which the MHP administered its daily business, and the cost thereof.

(B) Such books and records shall include, but shall not be limited to, all physical records originated or prepared pursuant to the performance under the MHP's contract including working papers, reports submitted to the Department, financial records, all medical and treatment records, medical charts and prescription files, and other documentation pertaining to services rendered to beneficiaries.

(C) These books and records shall be maintained for a minimum of three years after the final payment is made and all pending matters closed, or, in the event the MHP has been duly notified that the Department, DHCS, HHS, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

(3) Immediate on-site reviews of MHP program operations whenever the Department obtains information indicating that there is a threat to the health or safety of beneficiaries.

(4) Monitoring compliance with problem resolution process requirements contained in Subchapter 5 and the MHP's Implementation Plan.

(5) Monitoring provider contracts to ensure that the MHP enters into necessary contracts with DSH and Traditional Hospitals and that, pursuant to title 42 CFR section 438.230(a)(1), the MHP is accountable for any functions and responsibilities it has delegated to any subcontractor or another MHP.

(6) Monitoring denials of MHP payment authorizations.

(7) Annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, the services covered by the MHPs as required by Title 42, Code of Federal Regulations, Section 438.204.

(b) If the Department determines that an MHP is out of compliance with State or Federal laws and regulations or the terms of the contract between the MHP and the Department, the Department may take any or all of the following actions:

(1) Require that the MHP develop a plan of correction.

(2) Withhold all or a portion of payments due to the MHP from the Department.

(3) Impose civil penalties pursuant to Section 1810.385.

(4) Terminate the contract with the MHP pursuant to Section 1810.323.

(5) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

(c) If the Department determines that an action should be taken pursuant to Subsection (b), the Department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation

(2) A description of any corrective action required by the Department and time limits for compliance.

(3) A description of any and all proposed actions by the Department under this Section or Sections 1810.385 or 1810.323, and any related appeal rights.

(d) Except as provided in Section 1810.325, the MHP may appeal the Notice of Noncompliance to the Department, in writing, within 15 working days after the receipt of the notice, setting forth relevant facts and arguments. The Department shall grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. Except as provided in Section 1810.325, the Department shall suspend any proposed action pursuant to Subsection (c)(3) until the Department has acted on the MHP's appeal.

(e) In consultation with representatives from beneficiaries, their family members, MHPs, and selected other stakeholders, the Department shall develop, and update as appropriate, a comprehensive oversight program. The Department may effect this oversight program through administrative actions; incorporation into regulation as changes to this Section, to Implementation Plan requirements in Section 1810.310 or to other standards in this Chapter; and amendments to the contract between the Department and each MHP.

§ 1810.385. Civil Penalties.

(a) The Department may impose one or more of the civil penalties specified in Subsection (b) upon an MHP that fails to comply with the provisions of Sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, the provisions of this Chapter, or the terms of the MHP's contract with the Department.

(b) Civil penalties imposed by the Department shall be in the amounts specified below with respect to violation of:

(1) The provisions of Sections 1810.360, 1850.205, 1850.210, and 1850.215.

(A) First violation: \$1,000.

(B) Second and each subsequent violation: \$5,000.

(2) The provisions of Section 1810.375 and any other regulation or contract provision establishing a time frame for action.

(A) First violation: \$500, plus \$25 per day for each day that the item to be submitted is late.

(B) Second and each subsequent violation: \$500, plus \$25 per day for each day that the item to be submitted is late.

(3) Any provision of this Chapter that is not specifically addressed in this Section.

(A) First violation: \$500.

(B) Second violation: \$1,000.

(C) Third and each subsequent violation: \$5,000.

(4) Any provision of the contract between the MHP and the Department that is not specifically governed by this Chapter.

(A) First violation: \$500.

(B) Second and subsequent violations: \$1,000.

(5) Any provision of Sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, which is not specifically addressed in this Chapter.

(A) First violation: \$1,000.

(B) Second and subsequent violations: \$1,000.

(c) When the Department issues a notice of noncompliance as described in Section 1810.380 to an MHP found by the Department to be in violation of any provision of law, regulation or the contract, failure to comply with corrective actions in the notice within the time limits given shall be deemed to be a subsequent violation under this Section.

§ 1810.405. Access Standards for Specialty Mental Health Services.

(a) The MHP of the beneficiary shall be responsible for assuring that the beneficiary has access to specialty mental health services as provided in Section 1810.345 and Section 1810.350.

(b) Referrals to the MHP for Specialty Mental Health Services may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to:

(1) Physical health care providers

(2) Schools

(3) County welfare departments

(4) Other MHPs

(5) Conservators, guardians, or family members

(6) Law enforcement agencies.

(c) To treat a beneficiary's urgent condition, each MHP shall make specialty mental health services available 24 hours a day, seven days a week. If the MHP requires that a provider obtain approval of an MHP payment authorization request prior to the delivery of a specialty mental health service to treat a beneficiary's urgent condition as a condition of payment to the provider, the MHP shall have a statewide, toll-free telephone number available 24 hours a day, seven days per week, to act on MHP payment authorization requests for specialty mental health services to treat a beneficiary's urgent condition. Under these circumstances, the MHP shall act on the MHP payment authorization request within one hour of the request.

(d) Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

(e) At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional, other than a psychiatric technician or a

licensed vocational nurse, employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

(f) The MHP shall maintain a written log of the initial requests for specialty mental health services from beneficiaries of the MHP. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request. An MHP may submit requests to the Department for approval of alternative mechanisms that will track initial requests for specialty mental health services. The alternative mechanism shall include the information required of the written log. The data in the alternative mechanism shall be accessible to review by the Department. Requests for approval for alternative mechanisms shall be submitted as components of or changes to the MHP's Implementation Plan pursuant to Section 1810.310.

§ 1810.410. Cultural and Linguistic Requirements.

(a) Definitions:

(1) "Key points of contact" means common points of access to specialty mental health services from the MHP, including but not limited to the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.

(2) "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

(3) "Threshold Language" means a language that has been identified as the primary language, as indicated on the MEDS, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

(b) Each MHP shall comply with the cultural competence and linguistic requirements included in this Section, the terms of the contract between the MHP and the Department, and the MHP's Cultural Competence Plan established pursuant to Subsection (c). The terms of the contract between the MHP and the Department may provide additional requirements for the Cultural Competence Plan, including a description of the acceptable data sources and requirements for arraying data for the components of the Cultural Competence Plan.

(c) Each MHP shall develop and implement a Cultural Competence Plan that includes the following components:

(1) Objectives and strategies for improving the MHP's cultural competence based on the assessments required in Subsection (c)(2) and the MHP's performance on the standards in Subsection (d).

(2) A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability.

(3) A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services, pursuant to Section 1810.360 (f)(1).

(4) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

(d) The Department shall establish timelines for the submission and review of the Cultural Competence Plan described in Subsection (b) either as a component of the Implementation Plan process described in Section 1810.310 or as a term of the contract between the MHP and the Department. The MHP shall submit the Cultural Competence Plan to the Department for review and approval in accordance with these timelines. The MHP shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually.

(e) Each MHP shall have:

(1) A statewide, toll-free telephone number as required by Section 1810.405(d).

(2) Oral interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

(A) The MHP has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

(B) The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

(3) Policies and procedures to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the specialty mental health services or related services available through that key point of contact.

(4) General program literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure required by Section 1810.360(c), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and mental health education materials used by the MHP, in threshold languages, based on the threshold languages in the county as a whole.

§ 1810.415. Coordination of Physical and Mental Health Care.

(a) The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP.

(b) The MHP shall arrange appropriate management of a beneficiary's care, including the exchange of medical information, with a beneficiary's other health care providers or providers of specialty mental health services. The MHP shall maintain the confidentiality of medical records in accordance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(c) The MHP shall coordinate with pharmacies and Medi-Cal managed care plans as appropriate to assist beneficiaries to receive prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures.

(d) When the MHP determines that the beneficiary's diagnosis is not included in Section 1830.205(b)(1) or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary to:

(1) A provider outside the MHP, which may include:

(A) Whenever possible, a provider with whom the beneficiary already has a patient-provider relationship;

(B) The Medi-Cal managed care plan in which the beneficiary is enrolled;

(C) A provider in the area who has indicated to the MHP a willingness to accept MHP referrals, including federally qualified health centers, rural health clinics, and Indian health clinics; or

(2) An entity that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, which may include, where appropriate:

(A) The health care options program described in Section 14016.5 of the Welfare and Institutions Code;

(B) The local Child Health and Disability Prevention program as described in Title 17, Section 6800 et seq.;

(C) Provider organizations;

(D) Other community resources available in the county of the MHP.

The MHP of the beneficiary shall not be required to ensure the beneficiary's access to physical health care based treatment or to ensure the beneficiary's access to treatment from licensed mental health professionals for diagnoses not covered in Section 1830.205(b)(1). When the situation generating a referral under this Subsection meets the criteria established in Section 1850.210(i), a notice of action will be provided in accordance with that Section.

§ 1810.425. Hospital Selection Criteria.

An MHP shall establish a hospital selection process that meets the following criteria:

(a) The MHP shall require that each hospital:

(1) Comply with federal Medicaid laws, regulations and guidelines and State statutes and regulations and not violate the terms of the contract between the MHP and the Department.

(2) Sign a provider agreement with the State Department of Health Services.

(3) Provide psychiatric inpatient hospital services, within its scope of licensure, to all beneficiaries who are referred by the MHP, unless compelling clinical circumstances exist that contraindicate admission, or the MHP negotiates a different arrangement with the hospital.

(4) Refer beneficiaries for other services when necessary.

(5) Not refuse an admission solely on the basis of age, sex, race, religion, physical or mental disability, or national origin.

(b) In addition to the specified conditions in Subsection (a), an MHP may consider but is not limited to any or all of the following in selecting hospitals:

(1) History of Medi-Cal certification, licensure and accreditation.

(2) Circumstances and outcomes of any current or previous litigation against the hospital.

(3) The geographic location(s) that would maximize beneficiary participation.

(4) Ability of the hospital to:

(A) Offer services at competitive rates.

(B) Demonstrate positive outcomes and cost effectiveness.

(C) Address the needs of beneficiaries based on factors including age, language, culture, physical disability, and specified clinical interventions.

(D) Serve beneficiaries with severe mental illness and serious emotional disturbances.

(E) Meet the quality improvement, authorization, clinical and administrative requirements of the MHP.

(F) Work with beneficiaries, their families and other providers in a collaborative and supportive manner.

§ 1810.430. Contracting for Psychiatric Inpatient Hospital Service Availability.

(a) An MHP shall contract with DSH and Traditional Hospitals when:

(1) The DSH or Traditional Hospital meets the hospital selection criteria described in the MHP's Implementation Plan as required by Section 1810.310(a)(4).

(2) The DSH is located:

(A) In the same county as the MHP, or

(B) In a different county than the MHP and according to the latest historical Medi-Cal paid claims data, the DSH provides services to beneficiaries of the MHP that account for five percent or twenty thousand dollars, whichever is more, of the total fiscal year Fee-For-Service/Medi-Cal psychiatric inpatient hospital service payments for beneficiaries of the MHP.

(b) Prior to the beginning of each State fiscal year, the Department shall notify all MHPs of the DSH and Traditional Hospitals for that fiscal year.

(c)(1) If an MHP determines not to contract with a DSH or Traditional Hospital, it shall submit a Request for Exemption from Contracting to the Department with its Implementation Plan. The MHP shall submit Requests for Exemption initiated after the submission of the Implementation Plan to the Department as a separate submission. The Request for Exemption from Contracting shall address the projected effect on beneficiaries. At a minimum, the Request for Exemption from Contracting shall include:

(A) The name of the hospital for which the Request for Exemption from Contracting is requested.

(B) An analysis of the most recently available data from the Office of Statewide Health Planning and Development (OSHPD) on the availability, within an accessible geographic area, of hospital beds for psychiatric inpatient hospital services with and without a contract. Other data may be substituted if OSHPD data are not available or if equally reliable data are more comprehensive.

(C) The estimated impact on maximum and average travel time and distances for beneficiaries to obtain psychiatric inpatient hospital services, from hospitals either with or without a contract.

(2) An MHP shall notify the DSH or Traditional Hospital of the Request for Exemption from Contracting at the same time that the Request for Exemption is sent to the Department.

(3) The Department shall approve or deny in writing the MHP's Request for Exemption from Contracting within 30 calendar days of its receipt and shall notify both the MHP and the DSH or Traditional Hospital of its decision. The Department shall deny any Request for Exemption from Contracting when failure to contract is likely to result in hardship to beneficiaries as measured by local community standards.

(d) At a minimum, a contract between an MHP and a provider of psychiatric inpatient hospital services shall meet federal contracting requirements as provided in Title 42, Code of Federal Regulations, Section 438.6(l), and shall include the following provisions:

(1) Treatment requirements, as a condition for reimbursement for psychiatric inpatient hospital services, that ensure beneficiaries will receive the same level of services as provided to all other patients served.

(2) Assurances that beneficiaries will not be discriminated against in any manner, including admission practices, placement in special wings or rooms, or provision of special or separate meals.

(3) Specifics of how the hospital shall make records available for authorized review for fiscal audits, program compliance and beneficiary complaints.

(4) Language specifying that the per diem rate included in the contract is considered to be payment in full, subject to third party liability and patient share of costs, for psychiatric inpatient hospital services to a beneficiary.

(5) Language specifying that the rate structure in the contract includes all services defined as psychiatric inpatient hospital services in this Chapter and that the rate structure does not include psychiatric inpatient hospital professional services rendered to a beneficiary covered under the contract unless the hospital is a Short-Doyle/Medi-Cal Hospital.

(6) Requirements that a hospital adheres to Title XIX of the Social Security Act and conforms to federal and State statutes and regulations.

(7) If the contract is in excess of \$10,000 and utilizes State funds, a provision that: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after the final payment under contract (Government Code section 8546.7)." The MHP shall also be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code section 8546.7).

(e) For providers of Psychiatric Inpatient Hospital services that conduct utilization management activities, the MHP must ensure that the compensation arrangements in the contract are not structured so as to provide incentives for the provider of Psychiatric Inpatient Hospital services to deny, limit, or discontinue medically necessary services to any beneficiary.

(f) Written policies that address a beneficiary's rights as required by title 42 CFR section 438.100 shall be included in the contracts.

(g) No provision of a contract shall be construed to replace or conflict with the duties of county patients' rights advocates described in Section 5520 of the Welfare and Institutions Code.

(h) A formal contract between an MHP and a hospital is not required when the MHP owns or operates the hospital.

§ 1810.435. MHP Individual, Group and Organizational Provider Selection Criteria.

(a) Each MHP shall establish individual, group, and organizational provider selection criteria that comply with the requirements of this Section, the terms of the contract between the MHP and the Department, and the MHP's Implementation Plan pursuant to Section 1810.310.

(b) In selecting individual or group providers with which to contract, the MHP shall require that each individual or group provider:

(1) Possess the necessary license or certification to practice psychotherapy independently. Each individual practicing as part of a group provider shall possess the necessary license or certification.

(2) Maintain a safe facility.

(3) Store and dispense medications in compliance with State and federal laws and regulations.

(4) Maintain client records in a manner that meets state and federal standards.

(5) Meet the MHP's Quality Management Program standards.

(6) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(c) In selecting organizational providers with which to contract, the MHP shall require that each provider:

(1) Possess the necessary license to operate.

(2) Provide for appropriate supervision of staff.

(3) Have as head of service a licensed mental health professional or mental health rehabilitation specialist as described in Sections 622 through 630.

(4) Possess appropriate liability insurance.

(5) Maintain a safe facility.

(6) Store and dispense medications in compliance with all pertinent State and federal standards.

(7) Maintain client records in a manner that meets State and federal standards.

(8) Meet the MHP's Quality Management Program standards and requirements.

(9) Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to Section 1840.105.

(10) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(d) The MHP shall certify that a provider other than the MHP meets the criteria in subsections (b) or (c) prior to the provision of specialty mental health services under this Chapter, unless another time frame is provided in the contract between the Department and the MHP. For organizational providers, the MHP's certification process shall include an on site review in addition to a review of relevant documentation. The MHP may accept the certification of a provider by another MHP or by the Department.

(e) When an organizational provider is the MHP, the Department shall certify that each specific office or facility owned or operated by the MHP meets the criteria in Subsections (b) and (c), of the contract between the Department and the MHP. Unless another time frame is provided in the contract between the Department and the MHP, the Department's certification shall be obtained by the MHP prior to use of the provider for the provision of specialty mental health services under this Chapter. The Department's certification process shall include an on-site review of the office or facility in addition to a review of relevant documentation.

§ 1810.436. MHP Individual, Group and Organizational Provider Contracting R

(a) At a minimum, a contract between an MHP and a provider shall meet federal contracting requirements as provided in Title 42, Code of Federal Regulations, Section 438.6(l), and shall include the following provisions:

(1) Treatment requirements, as a condition for reimbursement, that ensure beneficiaries will receive the same level of services as provided to all other patients served.

(2) Assurances that beneficiaries will not be discriminated against in any manner.

(3) Specifics of how the provider shall make records available for authorized review for fiscal audits, program compliance and beneficiary complaints.

(4) Language specifying that the rate included in the contract is considered to be payment in full, subject to third party liability and beneficiary share of cost, for the specialty mental health services provided to a beneficiary.

(5) Requirements that the provider adhere to Title XIX of the Social Security Act and conform to other federal and State statutes and regulations.

(6) If the contract is in excess of \$10,000 and utilizes State funds, a provision that: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code section 8546.7)." The MHP shall also be subject to the examination and audit of the State

Auditor General for a period of three years after final payment under contract (Government Code section 8546.7).

(b) For Individual, Group and Organizational Providers that conduct utilization management activities, the MHP must ensure that the compensation arrangements in the contract are not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any beneficiary.

(c) No provision of a contract shall be construed to replace or conflict with the duties of county patients' rights advocates described in Section 5520 of the Welfare and Institutions Code.

(d) Written policies that address a beneficiary's rights as required by title 42 CFR section 438.100 shall be included in the contracts.

§ 1810.438. Alternative Contracts and Payment Arrangements Between MHPs and P

(a) Except as provided in Subsection (d), the MHP shall request approval from the Department to establish a contract with a provider for specialty mental health services where that provider is held financially responsible for specialty mental health services provided to beneficiaries by one or more other providers or to establish a payment arrangement with contract or non-contract providers that would not be allowed under this Chapter absent approval under this Section.

(b) The MHP may request approval from the Department under this Section by submitting a written request to the Department containing a description of:

(1) The proposed contract terms concerning reimbursement or the proposed payment arrangement. For providers that will conduct utilization management activities, the MHP must ensure that the compensation arrangements in the contract are not structured so as to provide incentives for the provider to deny, limit, or discontinue medically necessary services to any beneficiary.

(2) A complete description of the administrative system of the provider and the MHP that will ensure proper payment to the provider, claiming of the FFP available for services provided to Medi-Cal beneficiaries under the Medi-Cal program, and MHP and provider cost reporting. If the contract is in excess of \$10,000 and utilizes State funds, a provision that: "The contracting parties shall be subject to the examination and audit of the Auditor General for a period of three years after final payment under contract (Government Code section 8546.7)." The MHP shall also be subject to the examination and audit of the State Auditor General for a period of three years after final payment under contract (Government Code section 8546.7).

(c) The MHP shall not implement the proposed contract terms or payment arrangement until written approval by the Department is received. The Department shall review the proposal and approve the request only if the following conditions are met:

(1) The proposed contract or payment arrangement complies with federal and state requirements for reimbursement for specialty mental health services.

(2) The MHP has established appropriate systems to prevent duplicate claiming of FFP.

(3) The MHP has established appropriate procedures to assure that services provided under the contract or payment arrangement are reported by only one provider in cost and data reporting to the Department.

(d) Written policies that address beneficiary's rights as required by title 42 CFR section 438.100 shall be included in the contracts.

(e) Contracts between the MHP and a Fee-for-Service/Medi-Cal hospital that include psychiatric inpatient hospital professional services pursuant to Section 5781 of the Welfare and Institutions Code shall not require approval from the Department.

(f) Nothing in this Section shall exclude or exempt a provider from compliance with licensing requirements for health care service plans and specialized health care service plans under Section 1340 et seq. of the Health and Safety Code.

(g) A negotiated case rate or capitation rate of payment between an MHP and a provider pursuant to this Section shall not be the basis for finding a violation of the requirements of Title 22, Sections 51501(a) or 51480 and shall not be the basis for otherwise reducing the provider's reimbursement pursuant to Title 22, Division 3, Subdivision 1, Chapter 3, Article 7. A case rate is a payment method that reimburses the provider a set rate per time period per patient who receives at least one service during the time period, regardless of the actual number of services provided. A capitation rate is a payment method that reimburses the provider a set rate per time period, usually per month, per identified patient for all services needed by the patient, whether or not any services are received.

(h) The MHP shall obtain approval from the Department prior to implementing a Physician Incentive Plan as described at title 42 CFR section 438.6(h). The Department shall approve the MHP's request only if the proposed Physician Incentive Plan complies with all applicable federal and State regulations.

§ 1810.439. Provider-Beneficiary Communications.

In compliance with title 42 CFR section 438.102(a)(1), the MHP shall not prohibit, or otherwise restrict, a licensed, waived or registered professional as defined in sections 1810.223 and 1810.254 acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary for whom the provider is providing mental health services.

§ 1810.440. MHP Quality Management Programs.

The MHP shall establish a Quality Management Program in accordance with the terms of the contract between the MHP and the Department that includes at least the following elements:

(a) A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries by the MHP that:

(1) Is accountable to the director of the MHP.

(2) Has active involvement in planning, design and execution from:

(A) Providers;

(B) Beneficiaries who have accessed specialty mental health services through the MHP; and

(C) Parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.

(3) Ensures that the persons participating in the Quality Improvement Program under Subsection (a)(2) shall not be subject to discrimination or any other penalty in their other relationships with the MHP as a result of their role in representing themselves and their constituencies in the Quality Improvement Program.

(4) Includes substantial involvement of a licensed mental health professional.

(5) Conducts monitoring activities including but not limited to review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

(6) Is reviewed by the MHP and revised as appropriate annually.

(b) A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP that:

(1) Assures that the access and authorization criteria established in this Chapter are met.

(2) Conducts monitoring activities to ensure that the MHP meets the established standards for authorization decision making and takes action to improve performance if necessary.

(3) Is reviewed by the MHP and revised as appropriate annually.

(c) A beneficiary documentation and medical records system that meets the requirements of the contract between the MHP and the Department and requirements of State and federal law and regulation governing beneficiary documentation and medical records systems, including the following:

(1) Client plans signed (or electronic equivalent) by:

(A) The person providing the service(s), or

(B) A person representing a team or program providing services, or

(C) A person representing the MHP providing services.

(2) Documentation of the beneficiaries' participation in and agreement with their client plans. Documentation of participation in and agreement with the client plan may include, but is not limited to reference in the client plan to the beneficiary's participation in and

agreement with the client plan, the beneficiary's signature on the client plan, or a description in the medical record of the beneficiary's participation and agreement with the client plan, except as follows:

(A) The MHP shall obtain the beneficiary's signature or the signature of the beneficiary's legal representative on the client plan when:

1. The beneficiary is expected to be in long term treatment as determined by the MHP and
2. The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service.

(B) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan under Subsection (d)(1) and the beneficiary refuses to sign the client plan or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.

§ 1820.100. Definitions.

(a) "Allowable Psychiatric Accommodation Code" means a code that may be used by Fee-For-Service/Medi-Cal hospitals and MHPs to establish negotiated rates for psychiatric inpatient hospital services provided to beneficiaries. The allowable codes are:

097 Psychiatric Acute (Adolescent and Child)

114 Room and Board, Private, Psychiatric

124 Room and Board, Semi-Private 2 Bed, Psychiatric

134 Room and Board, Semi-Private 3 or 4 Bed, Psychiatric

154 Room and Board - Ward (Medical or General), Psychiatric

169 Administrative Days

204 Intensive Care, Psychiatric

(b) "Located" means the actual physical location of a hospital, and unless otherwise specified, refers to the specific county within the geographic boundaries of which the hospital exists.

(c) "Per Diem Rate" means a daily rate paid for reimbursable psychiatric inpatient hospital services for a beneficiary for the day of admission and each day that services are provided excluding the day of discharge.

§ 1820.110. Rate Setting for Psychiatric Inpatient Hospital Services for Negotiated Rate, F

(a) Except as approved by the Department pursuant to Section 1810.438, reimbursement for acute psychiatric inpatient hospital services for each Fee-for-

Service/Medi-Cal hospital with a contract with any MHP, shall be based on a per diem rate established through negotiations between the hospital and the MHP in the county in which the hospital is located except when:

- (1) The MHP from the county in which the hospital is located delegates the rate negotiation responsibilities to an MHP in another county with the agreement of that MHP.
 - (2) The MHP from the county in which the hospital is located declines to contract with the hospital or is otherwise exempt from contracting under this Subchapter and another MHP wants to negotiate rates. The MHP shall request approval from the Department to be designated as the negotiator. The Department shall approve the request unless approval has already been given to another MHP.
 - (3) The hospital is located in a border community and an MHP wants to negotiate rates. The MHP shall request approval from the Department to be designated as the negotiator.
 - (4) A hospital is owned or operated by the same organizational entity as the MHP. The per diem rate must be submitted by the MHP and approved by the Department. The Department shall approve a per diem rate submitted by the MHP if it is not greater than the highest per diem rate within the State, negotiated by a different MHP for a different hospital.
- (b) Except as approved by the Department pursuant to Section 1810.438, the per diem rate shall include routine hospital services and all hospital-based ancillary services.
- (c) Except as approved by the Department pursuant to Section 1810.438, only one rate for each allowable psychiatric accommodation code for each negotiated rate Fee-for-Service/Medi-Cal hospital may be established and shall be used by all MHPs with that hospital. The negotiated rate shall not be subject to retrospective adjustment to cost.
- (d) Except as approved by the Department pursuant to Section 1810.438, reimbursement for administrative day services shall be the rate established in accordance with Title 22, Section 51542 except for facility-specific reimbursements determined by the State Department of Health Services in accordance with Title 22, Section 51511(a)(2)(B) plus an allowance for hospital-based ancillary services equal to 25 percent of the maximum rate established under Title 22, Section 51542(a)(3).
- (e) For both acute psychiatric inpatient hospital services and administrative day services, reimbursement to the hospital shall be based on the per diem rate, less third party liability and patient share of cost.
- (f) Except as approved by the Department pursuant to Section 1810.438, the hospital shall submit reimbursement claims for Medi-Cal psychiatric inpatient hospital services to the fiscal intermediary based on its usual and customary charges.
- (g) Except as approved by the Department pursuant to Section 1810.438, at the end of each fiscal year, the Department shall compare, in aggregate, usual and customary charges to per diem rate for each hospital. Future claims shall be offset by the amount that the per diem rate exceeds the usual and customary charges for that fiscal year.

(h) Except as approved by the Department pursuant to Section 1810.438, the per diem rate included in the contract less third party liability and patient share of costs shall be considered to be payment in full for acute psychiatric inpatient hospital services to a beneficiary. The per diem rate established pursuant to Subsection (d) less third party liability and patient share of costs shall be considered to be payment in full for administrative day services to a beneficiary.

(i) The MHP shall not be responsible to reimburse Fee-for-Service/Medi-Cal hospitals that deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi-Cal program pursuant to Title 42, United States Code, Section 1396a(a)(n).

§ 1820.115. Rate Setting for Psychiatric Inpatient Hospital Services for Non-Negotiated
R

(a) Reimbursement rates for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal hospital with no contract with any MHP shall be determined by the Department.

(1) The reimbursement rates in Subsection (a) shall be calculated by the Department prior to the beginning of each fiscal year and shall not be modified for subsequent rate changes among Fee-for-Service/Medi-Cal contract hospitals or the addition of new Fee-for-Service/Medi-Cal contract hospitals.

(2) One rate per allowable psychiatric accommodation code per non-negotiated rate, Fee-for-Service/Medi-Cal hospital per Rate Region listed in Subsection (i) shall be established and shall be used by all MHPs.

(3) The rates shall not be subject to retrospective adjustment to cost.

(b) The per diem rate includes routine hospital services and all hospital-based ancillary services.

(c) The per diem rate by accommodation code shall equal the weighted average per diem rates by accommodation code negotiated for all Fee-for-Service/Medi-Cal hospitals within the Rate Region listed in Subsection (i) where the non-negotiated rate Fee-for-Service/Medi-Cal hospital is located or, if there are no Fee-for-Service/Medi-Cal hospitals with a negotiated rate by accommodation code within the Rate Region, the weighted average per diem rates by accommodation code negotiated for all Fee-for-Service/Medi-Cal hospitals statewide. The per diem rate shall be based on the following information from each Fee-for-Service/Medi-Cal hospital with a contract in the Rate Region where the non-negotiated rate Fee-for-Service/Medi-Cal hospital is located or statewide, if there are no Fee-for-Service/Medi-Cal hospitals with a negotiated rate by accommodation code within the Rate Region:

(1) The latest available fiscal year Medi-Cal paid claims data for Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days.

(2) The negotiated per diem rates by accommodation code for Fee-for-Service/Medi-Cal hospitals for the subsequent fiscal year.

(d) Reimbursement for administrative day services shall be the rate established in accordance with Title 22, Section 51542, except for facility-specific reimbursements determined by the State Department of Health Services in accordance with Title 22, Section 51511(a)(2)(B), plus an allowance for hospital-based ancillary services equal to 25 percent of the maximum rate established under Title 22, Section 51542(a)(3).

(e) For both acute psychiatric inpatient hospital services and administrative day services, interim reimbursement to the non-negotiated rate Fee-for-Service/Medi-Cal hospital shall be based on the calculated per diem rate less third party liability and patient share of cost.

(f) The hospital shall bill its usual and customary charges.

(g) At the end of each fiscal year, the Department shall compare, in aggregate, the usual and customary charges to the per diem rate for each hospital. Future claims shall be offset by the amount that the per diem rate exceeds the usual and customary charges for that fiscal year.

(h) The per diem rates established by this Section less third party liability and patient share of costs shall be considered to be payment in full for psychiatric inpatient hospital services to a beneficiary.

(i) The Rate Regions, including specified border communities, are:

(1) Superior - Butte, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity Counties, and Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, and Merrill, Oregon.

(2) Central Valley - Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, and Yuba Counties, and Carson City, Incline Village, Minden, Reno, Sparks, and Zephyr Cove, Nevada.

(3) Bay Area - Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma Counties.

(4) Southern California - Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura Counties, and Las Vegas and Henderson, Nevada; and Bullhead City, Kingman, Lake Havasu City, Parker and Yuma, Arizona.

(5) Los Angeles County.

(j) The MHP shall not be responsible to reimburse Fee-for-Service/Medi-Cal hospitals that deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi-Cal program pursuant to Title 42, United States Code, Section 1396a(a)(n).

§ 1820.120. Rate Setting for Psychiatric Inpatient Hospital Services for Short-D

(a) Except as approved by the Department pursuant to Section 1810.438, reimbursement for acute psychiatric inpatient hospital services for Short-Doyle/Medi-Cal hospitals shall be established in accordance with Section 1840.105.

(b) Except as approved by the Department pursuant to Section 1810.438, reimbursement for administrative day services for Short-Doyle/Medi-Cal hospitals shall be established in accordance with Title 22, Section 51542.

§ 1820.200. Definitions.

(a) "Adverse Decision" means denial or termination of an MHP payment authorization by the MHP's Point of Authorization or by a Short-Doyle/Medi-Cal hospital's Utilization Review Committee that determines the MHP's authorization for payment.

(b) "Continued Stay Services" means psychiatric inpatient hospital services for beneficiaries that occur after admission.

(c) "County Medical Services Program" means the service delivery and payment system for health care for low-income persons who are not eligible for Medi-Cal and which is administered by the State Department of Health Services for counties.

(d) "Emergency Admission" means an admission of a beneficiary to a hospital due to an emergency psychiatric condition for psychiatric inpatient hospital services.

(e) "Planned Admission" means an admission of a beneficiary to a hospital with a contract with an MHP for the purpose of providing medically necessary treatment that cannot be provided in another setting or a lower level of care and is not an emergency admission. Planned admissions may occur in a non-contract hospital pursuant to the MHP's Implementation Plan, as provided in Section 1810.310(a)(7) of this Chapter.

(f) "Utilization Review Committee" means a committee that reviews services provided to determine appropriateness for psychiatric inpatient hospital services, identifies problems with quality of care, and meets the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

§ 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient H

(a) For Medi-Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)-(2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy or Early Childhood

(D) Tic Disorders

(E) Elimination Disorders

(F) Other Disorders of Infancy, Childhood, or Adolescence

(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)

(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder

(I) Schizophrenia and Other Psychotic Disorders

(J) Mood Disorders

(K) Anxiety Disorders

(L) Somatoform Disorders

(M) Dissociative Disorders

(N) Eating Disorders

(O) Intermittent Explosive Disorder

(P) Pyromania

(Q) Adjustment Disorders

(R) Personality Disorders

(2) Both the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.

b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

- a. Further psychiatric evaluation.
- b. Medication treatment.
- c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:

- (1) Continued presence of indications that meet the medical necessity criteria as specified in (a).
- (2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.
- (3) Presence of new indications that meet medical necessity criteria specified in (a).
- (4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

§ 1820.210. Hospital Utilization Control.

All hospitals shall comply with Federal requirements for utilization control pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D. These requirements include certification of need for care, evaluation and medical review, plans of care and utilization review plan. Each hospital shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care and to identify problems with quality of care. Composition of the committee shall meet the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

§ 1820.215. MHP Payment Authorization -General Provisions.

- (a) The MHP payment authorization shall be determined for:
 - (1) Fee-for-Service/Medi-Cal hospitals, by an MHP's Point of Authorization.
 - (2) Short-Doyle/Medi-Cal hospitals contracting with the MHP, by either:
 - (A) An MHP's Point of Authorization, or
 - (B) The hospital's Utilization Review Committee, as agreed to in the contract.
 - (3) Short-Doyle/Medi-Cal hospitals that do not have a contract with the MHP, by an MHP's Point of Authorization.
- (b) The MHP that approves the MHP payment authorization shall have financial responsibility as described in this Chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Sections 1850.405 and 1850.505 or unless the services are provided to individuals eligible for the County Medical

Services Program (CMSP). Services provided to individuals eligible for the CMSP shall be authorized by the MHP for that county, but the MHP will not be responsible for payment of those services.

(c) MHP payment authorization requests presented for authorization beyond the timelines specified in this Subchapter shall be accepted for consideration by the MHP when the MHP determines that the hospital was prevented from submitting a timely request because of a reason that meets one of the criteria specified below. The MHP may accept MHP payment authorization requests presented beyond the timelines specified in the Subchapter for other acceptable reasons as determined by the MHP. The hospital shall submit factual documentation deemed necessary by the MHP with the MHP payment authorization request. Any additional documentation requested by the MHP shall be submitted within 60 calendar days of the MHP's request. The documentation shall verify that the late submission was due to:

(1) A natural disaster that has:

(A) Destroyed or damaged the hospital's business office or records; or

(B) Substantially interfered with the hospital's agent's processing of requests for MHP payment authorization; or

(2) Delays caused by other circumstances beyond the hospital's control. Documentation shall include evidence that the circumstance causing the delay was reported to a law enforcement or fire agency, if the circumstance is required to be reported. Circumstances not considered beyond the control of the hospital include but are not limited to:

(A) Negligence by employees.

(B) Misunderstanding of program requirements.

(C) Illness or absence of any employee trained to prepare MHP payment authorizations.

(D) Delays caused by the United States Postal Service or any private delivery service.

§ 1820.220. MHP Payment Authorization by a Point of Authorization.

(a) A hospital shall submit a separate written request for MHP payment authorization of psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP for each of the following:

(1) The planned admission of a beneficiary.

(2) Ninety-nine calendar days of continuous service to a beneficiary, if the hospital stay exceeds that period of time.

(3) Upon discharge.

(4) Services that qualify for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(5) Administrative day services that are requested for a beneficiary.

(b) A hospital shall submit the request for MHP payment authorization for psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission.

(2) Within 14 calendar days after:

(A) Ninety-nine calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time.

(B) Discharge.

(C) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(c) Except as approved by the Department pursuant to Section 1810.438, a written request for MHP payment authorization to the Point of Authorization shall be in the form of:

(1) A Treatment Authorization Request (TAR) for Fee-for-Service/Medi-Cal hospitals; or

(2) As specified by the MHP for Short-Doyle/Medi-Cal hospitals.

(d) The Point of Authorization staff that approve or deny payment shall be licensed mental health or waived/registered professionals of the beneficiary's MHP.

(e) Except as approved by the Department pursuant to Section 1810.438, approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing:

(1) On the same TAR on which the Fee-for-Service/ Medi-Cal hospital requested MHP payment authorization or

(2) In an MHP payment authorization log maintained by the MHP for Short-Doyle/Medi-Cal hospitals.

(f) In accordance with title 42 CFR section 438.210(b)(2)(ii), the MHP shall consult with a hospital requesting authorization when appropriate.

(g) The MHP shall document that all adverse decisions regarding hospital requests for MHP payment authorization based on medical necessity criteria or the criteria for emergency admission were reviewed and approved:

(1) by a physician, or

(2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice.

(h) A request for an MHP payment authorization may be denied by a Point of Authorization if the request is not submitted in accordance with timelines in this Subchapter or does not meet medical necessity reimbursement criteria in Section 1820.205 or emergency psychiatric condition criteria in Section 1820.225(b) on an emergency admission or if the hospital has failed to meet any other mandatory requirements of the contract negotiated between the hospital and the MHP.

(i) A Point of Authorization shall approve or deny the request for MHP payment authorization within 14 calendar days of the receipt of the request and, for a request from a Fee-for-Service Medi-Cal hospital, shall submit the TAR to the fiscal intermediary within 14 calendar days of approval or denial. The MHP shall consider a possible extension in accordance with timelines of title 42 CFR section 438.210(d)(1). If the MHP extends the timeframe, the MHP shall provide the beneficiary with written notice of the decision on the date the decision to extend is made. The notice to the beneficiary shall advise the beneficiary of the reason for the decision and the beneficiary's right to file a grievance if the beneficiary disagrees with the decision. The Point of Authorization shall provide for an expedited review of an MHP payment authorization request in accordance with title 42, Code of Federal Regulations, Section 438.210(d)(2), when the MHP determines or the hospital certifies that following the 14 calendar day time frame would seriously jeopardize the beneficiary's life, health or ability to attain, maintain or regain maximum function.

(j) Point of Authorization staff may authorize payments for up to seven calendar days in advance of service provision.

(k) In accordance with title 42 CFR section 438.210(c), the MHP shall notify the requesting provider of any decision to deny an MHP payment authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice to the provider need not be in writing.

(l) Approval of the MHP payment authorization by a Point of Authorization requires that:

(1) Planned admission requests for an MHP's payment authorization shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services, as specified in Section 1820.205, any other requirements of this Subchapter that apply to the admission, and any mandatory requirements of the contract negotiated between the hospital and the MHP. The request shall be submitted and approved prior to admission.

(2) Emergency admissions shall not be subject to prior MHP payment authorization.

(3) A request for MHP payment authorization for continued stay services shall be submitted to the Point of Authorization as follows:

(A) A contract hospital's request shall be submitted within the timelines specified in the contract. If the contract does not specify timelines, the contract hospital shall be subject to the same timeline requirements as the non-contract hospitals.

(B) A non-contract hospital's request shall be submitted to the Point of Authorization not later than:

1. Within 14 calendar days after the beneficiary is discharged from the hospital, or
2. Within 14 calendar days after a beneficiary has received 99 continuous calendar days of psychiatric inpatient hospital services.

(4) Requests for MHP payment authorization for continued stay services shall be approved if written documentation has been provided to the MHP indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of service in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP.

(5) Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

(A) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute residential treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate, non-acute residential treatment facilities per week subject to the following requirements:

1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, non-acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

- a. The status of the placement option.

- b. Date of the contact.

- c. Signature of the person making the contact.

(C) An MHP may submit a request to the Department for approval to use an alternative to the procedures described in Subsection (j)(5)(B). The Department shall approve the request if the MHP establishes to the satisfaction of the Department that the alternative ensures that placement options for beneficiaries who are receiving administrative days are being considered in a timely manner.

(D) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage, the hospital has notified the Point of Authorization within 24 hours or as specified in the contract, prior to beginning administrative day services.

(6) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a hospital shall be approved by an MHP when necessary documentation, as specified in Section 1850.215, is submitted.

§ 1820.225. MHP Payment Authorization for Emergency Admissions by a Point of A

(a) The MHP shall not require a hospital to obtain prior MHP payment authorization for an emergency admission, whether voluntary or involuntary.

(b) The hospital providing emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in Section 1820.205, and due to a mental disorder, is:

(1) A current danger to self or others, or

(2) Immediately unable to provide for, or utilize, food, shelter or clothing.

(c) The hospital providing emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within ten calendar days of the time of presentation for emergency services, or within the timelines specified in the contract, if a time requirement is included as a term of the contract between the hospital and MHP.

(1) If the hospital cannot determine the MHP of the beneficiary, the hospital shall notify the MHP of the county where the hospital is located, within ten calendar days of the date of presentation for emergency services.

(2) The MHP for the county where the hospital is located shall assist the hospital to determine the MHP of the beneficiary. The hospital shall notify the MHP of the beneficiary within ten calendar days of the date of presentation for emergency services of determination of the appropriate MHP.

(d) Requests for MHP payment authorization for an emergency admission shall be approved by an MHP when:

(1) A hospital notified the Point of Authorization within ten calendar days of the date of presentation for emergency services or within the time required by contract, if a time requirement is included as a term of the contract between the hospital and MHP.

(2) Written documentation has been provided to the MHP that certifies that a beneficiary met the criteria in Subsection (b) at the time of admission.

(3) Written documentation has been provided to the MHP that certifies a beneficiary met the criteria in Subsection (b) for the day of admission.

(4) A non-contract hospital includes documentation that the beneficiary could not be safely transferred to a contract hospital or a hospital owned or operated by the MHP of the beneficiary, if the transfer was requested by the MHP.

(5) Any mandatory requirements of the contract negotiated between the hospital and the MHP are met.

(e) In accordance with title 42 CFR section 438.210(c), the MHP shall notify the requesting provider of any decision to deny an MHP payment authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice to the provider need not be in writing.

(f) After an emergency admission, the MHP of the beneficiary may:

(1) Transfer the beneficiary from a non-contract to a contract hospital or a hospital owned or operated by the MHP of the beneficiary as soon the patient is stable. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

(2) Choose to authorize continued stay with a non-contract hospital.

(g) In accordance with title 42 CFR section 438.210(b)(2)(ii), the MHP shall consult with a hospital requesting authorization when appropriate.

§ 1820.230. MHP Payment Authorization by a Utilization Review Committee.

(a) MHP payment authorization for psychiatric inpatient hospital services provided by a Short-Doyle/Medi-Cal hospital, if not made by an MHP's Point of Authorization pursuant to Section 1820.220, shall be made by the hospital's Utilization Review Committee.

(1) The hospital's Utilization Review Committee shall meet the Federal requirements for participants pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

(2) The decision regarding MHP payment authorization shall be documented in writing by the hospital's Utilization Review Committee.

(b) The hospital's Utilization Review Committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission.

(c) At the time of the initial MHP payment authorization, the hospital's Utilization Review Committee or its designee shall specify the date for the subsequent MHP payment authorization determination.

(d) Approval of MHP payment authorization by a hospital's Utilization Review Committee requires that:

(1) When documentation in the clinical record substantiates that the beneficiary met the medical necessity criteria, the hospital's Utilization Review Committee shall authorize payment for each day that services are provided.

(2) Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non-acute residential treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non-acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements.

1. The MHP or its designee can waive the requirement of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

§ 1830.100. General Provisions.

This Subchapter applies to specialty mental health services other than psychiatric inpatient hospital services.

§ 1830.105. Provider Rate Setting Standards and Requirements.

(a) Except as approved by the Department pursuant to Section 1810.438, the MHP shall reimburse organizational providers that provide services to beneficiaries of the MHP in accordance with Section 1840.105.

(b) The MHP shall reimburse individual and group providers that contract with the MHP in accordance with the terms of the contract.

(c) The MHP shall reimburse individual or group providers that provide services to beneficiaries of the MHP and that do not have a contract with the MHP at the rates established by the Medi-Cal program in Title 22, Division 3, Subdivision 1, Chapter 3, Article 7, unless a different rate is agreed to between the MHP and the provider, except as provided in Subsection (d).

(d) The MHP shall reimburse individual or group providers that provide psychiatric inpatient hospital professional services to a beneficiary of the MHP with an emergency medical condition and that do not have a contract with the MHP at the rates established by the Medi-Cal program in Title 22, Division 3, Subdivision 1, Chapter 3, Article 7.

(e) Individual and group providers shall bill the MHP the provider's usual and customary charges for the specialty mental health service rendered to the beneficiary. The rate paid by the MHP to individual and group providers less third party liability and beneficiary

share of cost shall be considered payment in full for the specialty mental health services provided to the beneficiary.

(f) Organizational providers shall bill the MHP in accordance with the cost settlement requirements described in Section 1840.105 that apply to the provider.

(g) The MHP shall not be responsible to reimburse providers who deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi-Cal program pursuant to Title 42, United States Code, Section 1396a(a)(n), unless the provider is an organizational provider contracting with or otherwise authorized by the MHP of the beneficiary.

§ 1830.115. Psychiatric Nursing Facility Services Rates.

Except as approved by the Department pursuant to Section 1810.438, the rate for psychiatric nursing facility services shall be the rate established by the State Department of Health Services in accordance with Title 22, Sections 51510, 51511, 51511.1, 51535, and 51535.1. The nursing facility shall bill its usual and customary charges. The rate established by this Section less third party liability and beneficiary share of cost shall be considered payment in full for the scope of services described in those Sections provided to the beneficiary.

§ 1830.205. Medical Necessity Criteria for MHP Reimbursement of Speciality Mental H

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Fourth Edition (1994), published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition

(G) Mood Disorders, except Mood Disorders due to a General Medical Condition

(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

(A) A significant impairment in an important area of life functioning.

(B) A reasonable probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

§ 1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental H

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in *T.L. v. Belshe*.

§ 1830.215. MHP Payment Authorization.

(a) The MHP may require that providers obtain MHP payment authorization of any or all specialty mental health services covered by this Subchapter as a condition of reimbursement for the service in accordance with the provisions of this Section. MHP payment authorization under this Section shall be provided in compliance with timelines and other provisions in title 42, Code of Federal Regulations, Section 438.210.

(b) The MHP's authorization function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization function; including any such persons or entities affiliated with a contracting provider to which the MHP has delegated the authorization function.

(c) The individuals who review and approve or deny requests from providers for MHP payment authorization shall be licensed mental health professionals or waived/registered professionals of the MHP of the beneficiary. Licensed psychiatric technicians and licensed vocational nurses may approve or deny such requests only when the provider indicates that the beneficiary to whom the specialty mental health services will be delivered has an urgent condition as defined in Section 1810.253.

(d) The MHP may require that providers obtain MHP payment authorization prior to rendering any specialty mental health service covered by this Subchapter as a condition of reimbursement for the service, except for those services provided to beneficiaries with emergency psychiatric conditions as provided in Sections 1830.230 and 1830.245.

(e) Notwithstanding the provisions of Subsections (a) and (d), the MHP shall require that providers obtain MHP payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services as required in the MHP contract with the Department.

(f) Notwithstanding the discretion given to MHPs in Subsections (a) and the requirements of Subsection (c), the MHP shall comply with the specific MHP payment authorization requirements of Sections 1830.230, 1830.245, and 1830.250.

(g) Whether or not the MHP payment authorization of a specialty mental health service is required pursuant to this Section, the MHP may require that providers notify the MHP of their intent to provide the service prior to the delivery of the service.

(1) If the MHP does not require notice or has not informed providers of the notice requirement, MHP payment authorization requests presented for authorization beyond the timelines established by the MHP shall be accepted for consideration by the MHP when the MHP determines that the provider was prevented from submitting a timely request because of a reason that meets one of the criteria specified in Subsections (g)(1)(A)-(B). The MHP may accept MHP payment authorizations requests presented beyond the timelines specified in the Subchapter for other acceptable reasons as determined by the MHP. The provider shall submit factual documentation deemed necessary by the MHP with the MHP payment authorization request. Any additional documentation requested by the MHP shall be submitted within 60 calendar days of the MHP's request. The documentation shall verify that the late submission was due to:

(A) A natural disaster that has:

1. Destroyed or damaged the provider's business office or records, or
2. Substantially interfered with the provider's agent's processing of requests for MHP payment authorization; or

(B) Delays caused by other circumstances beyond the provider's control. Documentation shall include evidence that the circumstance causing the delay was reported to a law

enforcement or fire agency, if the circumstance is required to be reported. Circumstances that shall not be considered beyond the control of the provider include but are not limited to:

1. Negligence by employees.
2. Misunderstanding of program requirements.
3. Illness or absence of any employee trained to prepare MHP payment authorizations.
4. Delays caused by the United States Postal Service or any private delivery service.

(2) If the MHP does require such notice, the MHP shall inform providers of this requirement by including the MHP requirement in a publication commonly available to all providers serving beneficiaries. If notice is required and given by the provider, the MHP shall consider requests for MHP payment authorization submitted beyond the timelines for submission established by the MHP in accordance with the provisions of Subsection (g)(1). If notice is required and not given by the provider, the MHP may deny requests for MHP payment authorization submitted beyond the timelines for submission established by the MHP, regardless of the reason for the late submission.

(h) In accordance with title 42 CFR section 438.210(b)(2)(ii), the MHP shall consult with a provider requesting authorization when appropriate.

§ 1830.220. Authorization of Out-of-Plan Services.

(a) "Out-of-Plan Services" means specialty mental health services covered by this Subchapter, other than psychiatric nursing facility services, provided to a beneficiary by providers other than the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary.

(b) The MHP shall be required to provide out-of-plan services, when the services are also available through the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary, only under the following circumstances:

(1) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services as described in Section 1820.225 to the extent provided in Section 1830.230.

(2) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric health facility services under the conditions described in Section 1830.245.

(3) When a beneficiary is out of county and develops an urgent condition and there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, especially in terms of timeliness of service.

(4) When there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, the geographic availability of providers, and community standards for availability of providers

in the county in which the beneficiary is placed and the beneficiary is placed out of county by:

(A) The Foster Care Program as described in Article 5 (commencing with Section 11400), Chapter 2, Part 3, Division 9 of the Welfare and Institutions Code, the Adoption Assistance Program as described in Chapter 2.1 (commencing with Section 16115), Part 4, Division 9 of the Welfare and Institutions Code, or other foster care arrangement.

(1) If the beneficiary is a child or youth of either the Foster Care Program, Adoption Assistance Program, or other type of foster care arrangement such as Kin-GAP, and is placed outside his/her county of origin, the MHP of the county of origin must make an authorization decision and notify the host county and the requesting provider, if applicable of that decision within three working days following the date of receipt of the request for service by the MHP of origin. If the MHP of the county of origin documents a need for additional information to evaluate the beneficiary's need for the service, an extension may be granted up to three working days from the date the additional information is received, or 14 calendar days from the receipt of the original Treatment Authorization Request, whichever is less.

(2) Within 30 calendar days of the date of authorization of service, the MHP of the county of origin shall arrange for reimbursement for the service provided to the child or youth through the host county or the requesting provider.

(3) If there is a disagreement between the MHP of the county of origin and the MHP of the host county, the MHPs shall resolve their differences through the arbitration process provided in Section 1850.405.

(B) A Lanterman-Petris-Short or Probate Conservator or other legal involuntary placement.

§ 1830.225. Initial Selection and Change of Person Providing Services.

(a) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide a beneficiary who has been determined by the MHP to meet the medical necessity criteria for outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative or targeted case management services an initial choice of the person who will provide the service to the beneficiary. At the election of the MHP, the MHP may limit the beneficiary's choice to either a choice between two of the individual providers contracting with the MHP, or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

(b) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative, or targeted case management services. At the election of the MHP, the MHP may limit the beneficiary's choice of another person to provide services, to either an individual provider contracting with the MHP, or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

§ 1830.230. Psychiatric Inpatient Hospital Professional Services.

(a) Notwithstanding any other provisions of this Chapter, the medical necessity criteria that apply to psychiatric inpatient hospital professional services are the medical necessity criteria in Section 1820.205.

(b) When the beneficiary is admitted to a Fee-for-Service/Medi-Cal hospital, the MHP shall not require prior authorization of psychiatric inpatient hospital professional services that do not exceed one service per day of acute psychiatric inpatient hospital services. On the day of admission, the MHP shall not require prior authorization of a psychiatrist service or a mental health or medication support service by a physician in addition to a service by an admitting licensed mental health professional who is not a physician.

§ 1830.245. Psychiatric Health Facility Services.

(a) Notwithstanding any other provision of this Chapter, the medical necessity criteria that apply to psychiatric health facility services are the medical necessity criteria of Section 1820.205.

(b) The MHP may not require a psychiatric health facility to obtain prior authorization for an admission when the beneficiary has an emergency psychiatric condition.

(c) If the MHP requires MHP payment authorization for psychiatric health facility services, MHP payment authorization for the admission of a beneficiary with an emergency psychiatric condition shall be made in accordance with the terms of the contract between the MHP and the psychiatric health facility or with the terms of the contract between another MHP and the psychiatric health facility, if the MHP does not have a contract with the psychiatric health facility and the contract between another MHP and the psychiatric health facility covers the admission. Where there is no contract between an MHP and the psychiatric health facility that covers the admission, the MHP payment authorization shall be approved by the MHP when:

(1) The psychiatric health facility notified the MHP's Point of Authorization within 24 hours of admission of a beneficiary to the facility.

(2) Written documentation that certifies that a beneficiary met the criteria in Section 1820.225(b) at the time of admission, for the day of admission, and for any additional days prior to discharge during which the beneficiary received psychiatric health facility services, has been provided to the MHP within 14 calendar days of discharge or after the beneficiary has received 99 continuous calendar days of psychiatric health facility services, whichever is sooner.

(3) If, after the emergency admission, the MHP of the beneficiary requests transfer of the beneficiary to a psychiatric health facility contracting with the MHP, a contract hospital, or a psychiatric health facility or hospital owned or operated by the MHP of the beneficiary and the psychiatric health facility does not transfer the beneficiary, documentation shall include evidence that the beneficiary could not be safely transferred. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the psychiatric health facility.

§ 1830.250. MHP Payment Authorization for Psychiatric Nursing Facility Services.

(a) The following conditions apply to the provisions of psychiatric nursing facility services by the MHP:

(1) The MHP of the beneficiary shall not exclude any nursing facility that is licensed and certified to provide psychiatric nursing facility services and is in good standing with the Medi-Cal program from providing services to the beneficiary on the grounds that the facility would be providing out-of-plan services pursuant to Section 1830.220.

(2) Psychiatric nursing facility services shall be billed by the psychiatric nursing facility to the fiscal intermediary, rather than the MHP.

(b) A psychiatric nursing facility shall submit a separate written request for MHP payment authorization of psychiatric nursing facility services to the Point of Authorization of the MHP of the beneficiary for each of the following:

(1) The planned admission of a beneficiary.

(2) Services the psychiatric nursing facility believes are medically necessary that exceed the days previously authorized by the MHP.

(3) Services that qualify for Medical Assistance Pending Fair Hearing pursuant to Section 1850.215.

(c) Unless there is a contract between the psychiatric nursing facility and the MHP that provides for different time frames, a psychiatric nursing facility shall submit the request for MHP payment authorization for psychiatric nursing facility services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission;

(2) Ten working days prior to the expiration date of a previous MHP payment authorization; or

(3) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing pursuant to Section 1850.215.

(d) A written request for MHP payment authorization to the Point of Authorization shall be in the form of a Treatment Authorization Request (TAR).

(e) Approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing on the same TAR on which the psychiatric nursing facility requested MHP payment authorization.

(f) A Point of Authorization shall approve, deny or defer the request for MHP payment authorization within three working days of the receipt of the request. If the request is deferred, the MHP shall advise the psychiatric nursing facility of the additional documentation required by the MHP. The Point of Authorization shall send an approved or denied TAR to the fiscal intermediary within 14 calendar days of the approval or denial.

(g) MHP payment authorizations shall be approved by the MHP's Point of Authorization as follows:

(1) Requests for MHP payment authorization for planned admissions and continued stays shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric nursing facility services, as specified in Section 1830.205, in addition to any other requirements of this Chapter that apply to the admission.

(2) An MHP payment authorization approved by the MHP for a specific time period shall not be terminated or reduced because the beneficiary receiving the psychiatric nursing facility services:

(A) Is on leave of absence from the facility, subject to the limitations described in Title 22, Section 51535, or

(B) Has exercised the bed hold option provided by Title 22, Sections 72520, 73504, 76506, and 76709.1, subject to the limitations of Title 22, Section 51535.1.

(3) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a psychiatric nursing facility shall be approved by the MHP when necessary documentation, as specified in Section 1850.215, is submitted.

(h) The MHP that approves the MHP payment authorization shall have financial responsibility as described in this Chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Sections 1850.405 and 1850.505.

§ 1840.100. Definitions.

(a) "Claiming" means the process by which MHPs may obtain FFP for the expenditures they have made for specialty mental health services to Medi-Cal beneficiaries.

(b) "Health Care Procedure Coding System (HCPCS)" means a coded listing and description of health care services and items as defined in Title 22, Section 51050, which is prepared and updated annually by the Centers for Medicare and Medicaid Services. HCPCS consists of the Current Procedural Terminology (CPT) Standard Edition, American Medical Association, Fourth Edition, 2001, and each of its subsequent revisions, and other codes and descriptions authorized by the Centers for Medicare and Medicaid Services to describe services and items not contained in the CPT. Unless a different definition is adopted by the State Department of Health Services in Title 22, Division 3, Subdivision 1, Chapter 3, beginning with Section 51000, the definitions of individual HCPCS codes used in this Subchapter are the definitions provided in HCPCS in accordance with Title 22, Section 51050.

(c) "Legal entity" means each MHP and each of the corporations, partnerships, agencies, or individuals providing specialty mental health services under contract with the MHP, except that legal entity does not include individual or group providers, Fee-For-Service/Medi-Cal hospitals or psychiatric nursing facilities.

(d) "Lockout" means a situation or circumstance under which FFP is not available for a specific specialty mental health service. Lockout as used in this Subchapter does not address whether or not the provider of a specific specialty mental health service is entitled to payment for that service from the MHP.

(e) "Reimbursement" means a payment of FFP.

(f) "Service functions" mean mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, psychiatric health facility services, and targeted case management in the context of claiming FFP.

(g) "Short-Doyle/Medi-Cal system" means the system operated by the State Department of Health Services for the purpose of claiming FFP for specialty mental health services covered by the MHP other than psychiatric inpatient hospital services in a Fee-For-Service/Medi-Cal hospital or psychiatric nursing facility services.

§ 1840.105. General.

(a) Except as provided in this Subchapter, FFP for specialty mental health services shall be based on the lowest of the following:

(1) The provider's usual and customary charge to the general public for the same or similar services, unless the provider is a nominal charge provider pursuant to Medicare rules at Title 42, Code of Federal Regulations, Section 413.13.

(2) The provider's reasonable and allowable cost of rendering the services, based on year-end cost reports and Medicare principles of reimbursement pursuant to Title 42, Code of Federal Regulations, Part 413 and as described in HCFA Publication 15-1, for providers not contracting on a negotiated rate basis.

(3) The negotiated rates for providers, including the MHP, contracting on a negotiated rate basis pursuant to Subchapter 2, Article 1, beginning with Section 1820.100; Subchapter 3, Article 1, beginning with Section 1830.100; or Sections 5705 or 5716 of the Welfare and Institutions Code.

(4) The maximum allowances established by Title 22, Section 51516, except that the definitions of individual specialty mental health services shall be the definitions in this Chapter. When crisis stabilization is claimed under this Subchapter, the maximum allowance provided in Title 22, Section 51516, for "crisis stabilization-emergency room" shall apply when the service is provided in a 24-hour facility, including a hospital outpatient department. The maximum allowance for "crisis stabilization-urgent care" shall apply when the service is provided in any other appropriate site.

(b) Reimbursement to the MHP, Short-Doyle/Medi-Cal hospitals, or organizational providers based on negotiated rates shall be subject to retrospective cost settlement that shares equally between the federal government and the legal entity the portion of the federal reimbursement that exceeds actual cost in the aggregate by the legal entity. In no case will payments exceed the established maximum allowances.

§ 1840.110. Claims Submission.

(a) Except as otherwise provided in this Subchapter, the MHP shall submit all claims for specialty mental health services provided to Medi-Cal beneficiaries by the MHP through the Short-Doyle/Medi-Cal system.

(b) Except for good cause, as specified in Title 22, Section 51008.5, and approved by the State Department of Health Services, claims for specialty mental health services shall be presented to the Department no later than six months after the month of service. The Department shall present such claims to the State Department of Health Services no later than seven months after the date of service.

(c) The Department shall resubmit a claim, which has been returned by the State Department of Health Services for correction or additional information, no later than three months after the month in which the claim was returned by the State Department of Health Services.

§ 1840.112. MHP Claims Certification and Program Integrity.

(a) Each MHP shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations Sections 438.604, 438.606, and Section 438.608, which are hereby incorporated by reference.

(b) Each MHP shall certify to the Department, in writing, each monthly claim prior to submission to the State for reimbursement. The certification shall attest to the following for each beneficiary with services included in the claim:

(1) An assessment of the beneficiary was conducted in compliance with the requirements established in the MHP contract with the Department.

(2) The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.

(3) The services included in the claim were actually provided to the beneficiary.

(4) Medical necessity was established for the beneficiary as defined under this chapter for the service or services provided, for the timeframe in which the services were provided.

(5) A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department

(6) For each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in the MHP contract with the Department.

(c) In compliance with title 42 CFR sections 433.15 and 455.18, the MHP's chief financial officer or equivalent or an individual with authority delegated by the chief financial officer shall sign the certification under penalty of perjury that the State share of payment for

services covered by the claim has been provided in order to satisfy the matching requirement for federal financial participation.

(d) The MHP shall have mechanisms that support the certification, including the certification that the services for which claims were submitted were actually provided to the beneficiary.

§ 1840.115. Alternative Contract Provider Rates.

FFP for payments to providers by the MHP based on Section 1810.438 shall be claimed on the basis of actual services provided in accordance with articles 2 and 3 of this Subchapter.

§ 1840.205. General.

(a) FFP for Short-Doyle/Medi-Cal hospitals shall be claimed through the Short-Doyle/Medi-Cal system in accordance with Section 1840.110.

(b) FFP for Fee-For-Service/Medi-Cal hospitals shall be claimed by the State Department of Health Services in the same manner as FFP is claimed for other Medi-Cal services billed to the fiscal intermediary.

§ 1840.210. Non-Reimbursable Psychiatric Inpatient Hospital Services.

(a) The MHP may claim FFP for psychiatric inpatient hospital services in a psychiatric health facility that is larger than 16 beds and is certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services or an acute psychiatric hospital that is larger than 16 beds only under the following conditions:

(1) The beneficiary is 65 years of age or older, or

(2) The beneficiary is under 21 years of age, or

(3) The beneficiary was receiving such services prior to his/her twenty-first birthday and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier.

(b) The restrictions in Subsection (a) regarding claiming FFP for services in acute psychiatric hospitals and psychiatric health facilities shall cease to have effect if federal law changes or a federal waiver is obtained and reimbursement is subsequently approved.

(c) The MHP may not claim FFP for psychiatric inpatient hospital services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

§ 1840.215. Lockouts for Psychiatric Inpatient Hospital Services.

(a) The following services are not reimbursable on days when psychiatric inpatient hospital services are reimbursed, except for the day of admission to psychiatric inpatient hospital services:

- (1) Adult Residential Treatment Services,
- (2) Crisis Residential Treatment Services,
- (3) Crisis Intervention,
- (4) Day Treatment Intensive,
- (5) Day Rehabilitation,
- (6) Psychiatric Nursing Facility Services, except as provided in Subsection (b),
- (7) Crisis Stabilization, and
- (8) Psychiatric Health Facility Services.

(b) Psychiatric Nursing Facility Services may be claimed for the same day as a psychiatric inpatient hospital services, if the beneficiary has exercised the bed hold option provided by Title 22, Sections 72520, 73504, 76506, and 76709.1, subject to the limitations of Title 22, Section 51535.1.

(c) When psychiatric inpatient hospital services are provided in a Short-Doyle/Medi-Cal hospital, in addition to the services listed in (a), psychiatrist services, psychologist services, mental health services, and medication support services are included in the per diem rate and not separately reimbursable, except for the day of admission.

§ 1840.302. Psychiatric Nursing Facility Services.

FFP for psychiatric nursing facility services shall be claimed by the State Department of Health Services in the same manner as FFP is claimed for other Medi-Cal services billed to the fiscal intermediary.

§ 1840.304. Crosswalk Between Service Functions and HCPCS Codes.

(a) When an individual or group provider bills and is paid by the MHP for psychiatrist, psychologist, or EPSDT supplemental specialty mental health services using CPT or other HCPCS codes, the MHP shall claim FFP by service function based on a crosswalk between allowable CPT and other HCPCS codes and service functions established by the Department pursuant to the contract between the MHP and the Department. The dollar amount claimed shall be in accordance with Section 1840.105.

(b) When a provider that is a hospital outpatient department bills and is paid by the MHP for facility room use using the HCPCS codes Z7500 or Z7502 in addition to the CPT or other HCPCS code for the specialty mental health service provided to the beneficiary, the MHP shall claim FFP for the combined codes under the CPT or other HCPCS codes for the specialty mental health service provided to the beneficiary that are listed on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a). When a provider bills the MHP using a CPT or other HCPCS code that is not included on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a) other than Z7500 or Z7502,

the MHP shall determine the appropriate service function for the service provided and shall claim FFP in accordance with Section 1840.308.

(c) The HCPCS codes listed on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a) may be billed by any individual or group providers acting within the scope of their practice.

(d) The lockouts described in Section 1840.215 and Sections 1840.360 through 1840.374 shall apply to claiming of FFP for services claimed under this Section. For the purpose of determining lockouts the service shall be considered to be the service function identified on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a).

(e) The crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a) shall not be used to claim FFP for services provided by organizational providers.

§ 1840.306. Psychiatrist, Psychologist, and EPSDT Supplemental Specialty Mental H

FFP for psychiatrist, psychologist, and EPSDT supplemental specialty mental health services shall be claimed through the Short-Doyle/Medi-Cal system in accordance with Section 1840.110, based on the provisions of Section 1840.304, including the crosswalk identified in Section 1840.304(a), unless the terms of the contract between provider and the MHP require the provider to provide and bill for services in accordance with Section 1840.308. The dollar amount claimed shall be in accordance with Section 1840.105.

§ 1840.308. Service Functions.

FFP for service functions shall be claimed through the Short-Doyle/Medi-Cal system in accordance with Section 1840.110. To be eligible for reimbursement, each service function shall have been provided in accordance with Sections 1840.314 through 1840.372. The services may be delivered either by individual, group, or organizational providers. The dollar amount claimed shall be in accordance with Section 1840.105.

§ 1840.312. Non-Reimbursable Services -General.

The following services are not eligible for FFP:

(a) Academic educational services.

(b) Vocational services that have as a purpose actual work or work training.

(c) Recreation.

(d) Socialization is not reimbursable if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

(e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.

(f) Medi-Cal program benefits that are excluded from coverage by the MHP as described in Section 1810.355.

(g) Specialty mental health services covered by this Article provided during the time a beneficiary 21 years of age through 64 years of age resides in any institution for mental diseases, unless:

(1) The beneficiary was receiving, prior to his/her twenty-first birthday, services in an institution for mental diseases and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier; and

(2) The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which FFP may be available include but are not limited to acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services.

(h) Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through 441.156. Facilities at which FFP may be available include acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as Medi-Cal providers of inpatient hospital services.

(i) The restrictions in Subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.

(j) Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5 to the extent that they are provided to beneficiaries whose Medi-Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services.

(k) The MHP may not claim FFP for specialty mental health services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

§ 1840.314. Claiming for Service Functions -General.

In order to receive FFP for provider payments made by the MHP or for services delivered directly by the MHP, the MPH must assure that the following requirements are met for all service functions:

(a) The provider must meet the standards for participation in the Medi-Cal program as established under Titles XVIII and XIX of the Social Security Act.

(b) Contacts with significant support persons in the beneficiary's life are directed exclusively to the mental health needs of the beneficiary.

(c) When services are being provided to or on behalf of a beneficiary by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the beneficiary.

(d) Services shall be provided within the scope of practice of the person delivering service, if professional licensure is required for the service.

(e) Services shall be provided:

(1) Under the direction of one or more of the following:

(A) Physician

(B) Psychologist

(C) Licensed Clinical Social Worker

(D) Marriage and Family Therapist

(E) Registered Nurse

(F) Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.

(2) Direction may include, but is not limited to being the person directly providing the service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. Individuals are not required to be physically present at the service site to exercise direction.

(f) Hospital outpatient departments as defined in Title 22, Section 51112, operating under the license of a hospital may only provide service functions in compliance with licensing requirements.

§ 1840.316. Claiming for Service Functions Based on Minutes of Time.

(a) For the following services the billing unit is the time of the person delivering the service in minutes of time:

(1) Mental Health Services

(2) Medication Support Services

(3) Crisis Intervention

(4) Targeted Case Management

(b) The following requirements apply for claiming of services based on minutes of time:

(1) The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or

claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.

(2) When a person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

(3) The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

(4) Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time may be billed regardless of whether there is a face-to-face or phone contact with the beneficiary.

§ 1840.318. Claiming for Service Functions on Half Days or Full Days of Time.

(a) Day treatment intensive and day rehabilitation shall be billed as half days or full days of service.

(b) The following requirements apply for claiming of services based on half days or full days of time:

(1) A half-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

(2) A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

(3) Although the beneficiary must receive face-to-face services on any full day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.

§ 1840.320. Claiming for Service Functions Based on Calendar Days.

(a) The following services are reimbursed based on calendar days:

(1) Adult Residential Treatment Services

(2) Crisis Residential Treatment Services

(3) Psychiatric Health Facility Services.

(b) The following requirements apply for claiming of services based on calendar days:

(1) A day shall be billed for each calendar day in which the beneficiary receives face-to-face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.

(2) Board and care costs are not included in the claiming rate.

(3) The day of admission may be billed but not the day of discharge.

§ 1840.322. Claiming for Service Functions Based on Hours of Time.

(a) Crisis Stabilization shall be reimbursed based on hours of time:

(b) The following requirements apply for claiming of services based on time:

(1) Each one-hour block that the beneficiary receives crisis stabilization services shall be claimed.

(2) Partial blocks of time shall be rounded up or down to the nearest one-hour increment except that services provided during the first hour shall always be rounded up.

§ 1840.324. Mental Health Services Contact and Site Requirements.

Mental Health Services may be either face-to-face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

§ 1840.326. Medication Support Services Contact and Site Requirements.

(a) Medication Support Services may be either face-to-face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

(b) Medication Support Services that are provided within a residential or day program shall be billed as Medication Support Services separately from the residential or day program service.

§ 1840.328. Day Treatment Intensive Services Contact and Site Requirements.

Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site.

§ 1840.330. Day Rehabilitation Services Contact and Site Requirements.

Day Rehabilitation Services shall have a clearly established site for services, although all services need not be delivered at that site.

§ 1840.332. Adult Residential Treatment Services Contact and Site Requirements.

(a) Adult Residential Treatment Services shall have a clearly established certified site for services, although all services need not be delivered at that site. Services shall not be claimable unless there is face-to-face contact between the beneficiary and a treatment

staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs that provide Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the Department as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program in accordance with Chapter 3, Division 1, of Title 9. Facility capacity must be limited to a maximum of 16 beds.

(c) In addition to Social Rehabilitation Program certification, programs which provide Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

§ 1840.334. Crisis Residential Treatment Services Contact and Site Requirements.

(a) Crisis Residential Treatment Services shall have a clearly established certified site for services although all services need not be delivered at that site. Services shall not be claimable unless there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs shall have written procedures for accessing emergency psychiatric and health services on a 24-hour basis.

(c) Programs providing Crisis Residential Treatment Services shall be certified as a Social Rehabilitation Program (Short-term Crisis Residential Treatment Program) by the Department in accordance with Chapter 3, Division 1, of Title 9. Facility capacity shall be limited to a maximum of 16 beds.

(d) In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services shall be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

§ 1840.336. Crisis Intervention Contact and Site Requirements.

Crisis Intervention may either be face-to-face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

§ 1840.338. Crisis Stabilization Contact and Site Requirements.

(a) Crisis Stabilization shall be provided on site at a licensed 24-hour health care facility or hospital based outpatient program or a provider site certified by the Department or an MHP to perform crisis stabilization.

(b) Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Immediate access and reasonable proximity shall be defined by the Mental Health Plan. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

(c) All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary's need shall be made, to the extent resources are available.

§ 1840.340. Psychiatric Health Facility Services Contact and Site Requirements.

(a) Psychiatric Health Facility Services shall have a clearly established certified site for services. Services shall not be claimable unless there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs providing Psychiatric Health Facility Services must be licensed as a Psychiatric Health Facility by the Department.

(c) Programs shall have written procedures for accessing emergency health services on a 24-hour basis.

§ 1840.342. Targeted Case Management Contact and Site Requirements.

Targeted Case Management may be either face-to-face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

§ 1840.344. Service Function Staffing Requirements -General.

Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Targeted Case Management, and Adult Residential Treatment Services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with state law.

§ 1840.346. Medication Support Services Staffing Requirements.

Medication Support Services shall be provided within the scope of practice by any of the following:

- (a) Physician
- (b) Registered Nurse
- (c) Licensed Vocational Nurse
- (d) Psychiatric Technician
- (e) Pharmacist

(f) Physician Assistant

§ 1840.348. Crisis Stabilization Staffing Requirements.

(a) A physician shall be on call at all times for the provision of those Crisis Stabilization Services that may only be provided by a physician.

(b) There shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times beneficiaries are present.

(c) At a minimum there shall be a ratio of at least one licensed mental health or waived/registered professional on site for each four beneficiaries or other patients receiving Crisis Stabilization at any given time.

(d) If the beneficiary is evaluated as needing service activities that can only be provided by a specific type of licensed professional, such persons shall be available.

(e) Other persons may be utilized by the program, according to need.

(f) If Crisis Stabilization services are co-located with other specialty mental health services, persons providing Crisis Stabilization must be separate and distinct from persons providing other services.

(g) Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.

§ 1840.350. Day Treatment Intensive Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight beneficiaries or other clients in attendance during the period the program is open:

(1) Physicians

(2) Psychologists or related waived/registered professionals

(3) Licensed Clinical Social Workers or related waived/registered professionals

(4) Marriage and Family Therapists or related waived/registered professionals

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

(c) Persons providing services in Day Treatment Intensive programs serving more than 12 clients shall include at least one person from two of the following groups:

- (1) Physicians
- (2) Psychologists or related waived/registered professionals
- (3) Licensed Clinical Social Workers or related waived/registered professionals
- (4) Marriage and Family Therapists or related waived/registered professionals
- (5) Registered Nurses
- (6) Licensed Vocational Nurses
- (7) Psychiatric Technicians
- (8) Occupational Therapists
- (9) Mental Health Rehabilitation Specialists as defined in Section 630.

§ 1840.352. Day Rehabilitation Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Rehabilitation services to ten beneficiaries or other clients in attendance during the period the program is open:

- (1) Physicians
- (2) Psychologists or related waived/registered professionals
- (3) Licensed Clinical Social Workers or related waived/registered professionals
- (4) Marriage and Family Therapists or related waived/registered professionals
- (5) Registered Nurses
- (6) Licensed Vocational Nurses
- (7) Psychiatric Technicians
- (8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons providing Day Rehabilitation who do not participate in the entire Day Rehabilitation session, whether full-day or half-day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities.

(c) Persons providing services in Day Rehabilitation programs serving more than 12 clients shall include at least two of the following:

(1) Physicians

(2) Psychologists or related waived/registered professionals

(3) Licensed Clinical Social Workers or related waived/registered professionals

(4) Marriage and Family Therapists or related waived/registered professionals

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

§ 1840.354. Adult Residential Treatment Services Staffing Requirements.

(a) Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Section 531(b), (c).

(b) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Adult Residential Treatment Services and function in other capacities.

§ 1840.356. Crisis Residential Treatment Services Staffing Requirements.

(a) Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with Section 531(a).

(b) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Crisis Residential Treatment Services and function in other capacities.

§ 1840.358. Psychiatric Health Facility Staffing Requirements.

(a) Staffing ratios in Psychiatric Health Facility Services shall be consistent with Title 22, Section 77061.

(b) Staffing qualifications shall be consistent with Title 22, Sections 77004, 77011.2, 77012, 77012.1, 77012.2, 77017, 77023, and 77079.12.

(c) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Psychiatric Health Facility Services and function in other capacities.

§ 1840.360. Lockouts for Day Rehabilitation and Day Treatment Intensive.

Day Rehabilitation and Day Treatment Intensive are not reimbursable under the following circumstances:

(a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission to those services.

(b) Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive is provided.

(c) Two full-day or one full-day and one half-day or two half-day programs may not be provided to the same beneficiary on the same day.

§ 1840.362. Lockouts for Adult Residential Treatment Services.

Adult Residential Treatment Services are not reimbursable under the following circumstances:

(a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission.

(b) When an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under the two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time.

§ 1840.364. Lockouts for Crisis Residential Treatment Services.

Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services:

(a) Mental Health Services

(b) Day Treatment Intensive

(c) Day Rehabilitation

(d) Psychiatric Inpatient Hospital Services

(e) Psychiatric Health Facility Services

(f) Psychiatric Nursing Facility Services

(g) Adult Residential Treatment Services

(h) Crisis Intervention

(i) Crisis Stabilization

§ 1840.366. Lockouts for Crisis Intervention.

(a) Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

(b) The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours.

§ 1840.368. Lockouts for Crisis Stabilization.

(a) Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed, except on the day of admission to those services.

(b) Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management.

(c) The maximum number of hours claimable for Crisis Stabilization in a 24-hour period is 20 hours.

§ 1840.370. Lockouts for Psychiatric Health Facility Services.

Psychiatric Health Facility Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Psychiatric Health Facility Services:

(a) Adult Residential Treatment Services

(b) Crisis Residential Treatment Services

(c) Crisis Intervention

(d) Day Treatment Intensive

(e) Day Rehabilitation

(f) Psychiatric Inpatient Hospital Services

(g) Medication Support Services

(h) Mental Health Services

(i) Crisis Stabilization

(j) Psychiatric Nursing Facility Services.

§ 1840.372. Lockouts for Medication Support Services.

The maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours.

§ 1840.374. Lockouts for Targeted Case Management Services.

(a) Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services as provided in Subsection (b):

(1) Psychiatric Inpatient Hospital Services

(2) Psychiatric Health Facility Services

(3) Psychiatric Nursing Facility Services

(b) Targeted Case Management Services, solely for the purpose of coordinating placement of the beneficiary on discharge from the hospital, psychiatric health facility or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.

§ 1850.205. General Provisions.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a problem or concern about any issue related to the MHP's performance of its duties under this Chapter, including the delivery of specialty mental health services.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A grievance process;

(2) An appeal process; and

(3) An expedited appeal process.

(c) For the grievance, appeal, and expedited appeal processes, found in Sections 1850.206, 1850.207 and 1850.208 respectively, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to Section 1850.210. For the purposes of this Section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making forms that may be used to file grievances, appeals, and expedited appeals, and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process.

(3) That a beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified by the MHP as having responsibility for assisting a beneficiary, at the beneficiary's request, with these processes, including assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing specialty mental health services to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for consideration in the MHP's Quality Improvement Program as required by Section 1810.440(a)(5).

(8) That the individuals making the decision on the grievance, appeal, or expedited appeal were not involved in any previous review or decision-making on the issue presented in the respective problem resolution process.

(9) That the individual making the decision on the grievance, appeal, or expedited appeal has the appropriate clinical expertise as determined by the MHP to treat the beneficiary's condition, if the grievance is regarding the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal is about clinical issues.

(d) For the grievance, appeal, and expedited appeal processes found in Sections 1850.206, 1850.207, and 1850.208, the MHP shall:

(1) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include but not be limited to the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem.

(2) Record in the grievance and appeal log or another central location determined by the MHP the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary, or document the reason(s) that there has not been final disposition of the grievance, appeal, or expedited appeal.

(3) Provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal.

(4) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing.

(5) Identify the roles and responsibilities of the MHP, the provider, and the beneficiary.

(6) Notify those providers cited by the beneficiary or otherwise involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

(e) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

§ 1850.206. The Grievance Process.

In addition to meeting the requirements of Section 1850.205, the grievance process shall, at a minimum:

(a) Allow beneficiaries to present their grievance orally or in writing.

(b) Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension or if the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Section 1810.230.5.

(c) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

§ 1850.207. The Appeal Process.

In addition to meeting the requirements of Section 1850.205, the appeal process shall, at a minimum:

(a) Allow a beneficiary to file an appeal orally or in writing.

(b) Require a beneficiary to follow an oral appeal with a written appeal. The date the MHP receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes in Subsection (c).

(c) Provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an extension or the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Section 1810.230.5.

(d) Inform the beneficiary of his or her right to request a fair hearing after the appeal process of the MHP has been exhausted.

(e) Allow the beneficiary to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.

(f) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process.

(g) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.

(h) Notify the beneficiary and/or his or her representative of the resolution of the appeal in writing. The notice shall contain:

(1) The results of the appeal resolution process.

(2) The date that the appeal decision was made.

(3) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal.

(i) Promptly provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services.

§ 1850.208. The Expedited Appeal Process.

In addition to meeting the requirements of Section 1850.205 and 1850.207(a), (d), (e), (f), (g), and (i), the expedited appeal process shall, at a minimum:

(a) Be used when the MHP determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

(b) Allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.

(c) Ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

(d) Resolve an expedited appeal and notify the affected parties in writing, no later than three working days after the MHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the MHP determines that there is need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Section 1810.230.5.

(e) Provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. The written notice shall meet the requirements of Section 1850.207(h).

(f) If the MHP denies a request for expedited appeal resolution, the MHP shall:

(1) Transfer the expedited appeal request to the timeframe for appeal resolution as required by Section 1850.207(c).

(2) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in Section 1810.230.5.

§ 1850.209. Beneficiary Problem Resolution Processes Established by Providers.

(a) Nothing in this Section and Sections 1850.205, 1850.206, 1850.207, and 1850.208 precludes a provider other than the MHP from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the

provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

(1) The MHP delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation.

(2) The provider's beneficiary problem resolution process fully complies with this Section, Section 1850.205, and, depending on processes delegated, Sections 1850.206, 1850.207, and/or 1850.208.

(3) No beneficiary is prevented from accessing the grievance, appeal or expedited appeal processes solely on the grounds that the grievance, appeal or expedited appeal was incorrectly filed with either the MHP or the provider.

§ 1850.210. Provision of Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary.

(1) Except as provided in Subsection (c), when the denial or modification involves a request from a provider for continued MHP payment authorization of a specialty mental health service or when the MHP reduces or terminates a previously approved MHP payment authorization, notice shall be provided in accordance with Title 22, Section 51014.1.

(2) Notice is not required when a denial is a non-binding verbal description to a provider of the specialty mental health services that may be approved by the MHP.

(3) Notice is not required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services.

(4) Except as provided in Subsection (b), notice is not required when the denial or modification is a denial or modification of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.

(b) A Notice of Action is required when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the MHP that the service was not medically necessary or otherwise was not a service covered by the MHP.

(c) The MHP shall deny the MHP payment authorization request and provide the beneficiary of the MHP with a Notice of Action when the MHP does not have sufficient information to approve or modify, or deny on the merits, an MHP payment authorization request from a provider within the timeframes required by Sections 1820.220 or 1830.215.

(d) The MHP shall provide the beneficiary of the MHP with a Notice of Action if the MHP fails to notify the affected parties of a grievance decision within 60 calendar days, an appeal decision within 45 days, or an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to Sections 1850.206, 1850.207 or 1850.208 respectively, the MHP shall provide a beneficiary of the MHP with a Notice of Action if the MHP fails to notify the affected parties of the grievance, appeal or expedited appeal decision within the extension period.

(e) The MHP shall provide a beneficiary of the MHP with a Notice of Action if the MHP fails to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP.

(f) The MHP shall comply with the requirements of Section 1850.212 regarding the content of Notices of Action and with the following timeframes for mailing of Notices of Action:

(1) The written Notice of Action issued pursuant to Subsections (a) or (b) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action, except that a Notice of Action issued pursuant to Subsection (a)(1) shall be provided in accordance with the applicable timelines of Title 22, Section 51014.1.

(2) The written Notice of Action issued pursuant to Subsections (c) or (d) shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

(3) The written Notice of Action issued pursuant to Subsection (e) shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the MHP expires.

(g) When a Notice of Action would not be required under Subsections (a), (b), or (c), the MHP shall provide a beneficiary of the MHP with Notice of Action under this Subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2), (b)(3)(C) or 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. A Notice of Action pursuant to this Subsection is not required when a provider, including the MHP acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the MHP, including but not limited to crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any specialty mental health service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other specialty mental health service covered by the MHP. The Notice of Action under this Subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with Subsection (f)(1) and shall specify the information contained in Section 1850.212(b).

(h) For the purpose of this Section, each reference to a Medi-Cal managed care plan in Title 22, Section 51014.1, shall mean the MHP.

(i) For the purposes of this Section, "medical service" as cited in Title 22, Section 51014.1, shall mean specialty mental health services that are subject to prior authorization by an MHP pursuant to Subchapters 2 and 3, beginning with Sections 1820.100 and 1830.100, respectively.

(j) The MHP shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to the Department, the Department of Health Services and other appropriate oversight entities as specified in the contract between the Department and the MHP.

§ 1850.212. Contents of a Notice of Action.

(a) The Notice of Action, issued pursuant to Section 1850.210(a)-(e) shall contain the following information:

(1) The action taken by the MHP.

(2) The reason for the action taken.

(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.

(4) The beneficiary's right to file an appeal or expedited appeal with the MHP.

(5) The beneficiary's right to a fair hearing or to request an expedited fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.

(D) The time limits for requesting a fair hearing or an expedited fair hearing.

(b) A Notice of Action, issued pursuant to Section 1850.210(g), shall specify the following:

(1) The reason that the medical necessity criteria were not met, including a citation of the applicable regulation.

(2) The beneficiary's options for obtaining care outside the MHP, if applicable.

(3) The beneficiary's right to request a second opinion on the determination.

(4) The beneficiary's right to file an appeal or expedited appeal with the MHP.

(5) The beneficiary's right to a fair hearing or to request an expedited fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self-represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limits for requesting a fair hearing or an expedited fair hearing.

§ 1850.213. Fair Hearings.

(a) The fair hearings under this Article shall be administered by the State Department of Health Services, in accordance with Title 22, Sections 50951 and 50953.

(b) The MHP shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the MHP's responsibilities under the contract between the MHP and the Department.

(c) Nothing in this section is intended to prevent the MHP from pursuing any options available for appealing a fair hearing decision.

§ 1850.215. Continuation of Services Pending Fair Hearing Decision.

(a) A beneficiary receiving specialty mental health services pursuant to this Chapter shall have a right to file for continuation of specialty mental health services pending fair hearing pursuant to Title 22, Section 51014.2. The time limits for filing for a continuation of services pursuant to Title 22, Section 51014.2 shall not be extended by a beneficiary's decision to pursue an MHP's beneficiary problem resolution process as described in Section 1850.205.

(b) The MHP shall provide continuation of specialty mental health services pending a fair hearing in accordance with Title 22, Section 51014.2. If an MHP allows providers to deliver specialty mental health services for a set number of visits or a set duration of time without prior authorization, the MHP shall provide continuation of specialty mental health services pending a fair hearing when the MHP denies an MHP payment authorization request from a provider requesting continuation of services beyond the number or duration permitted without prior authorization and the beneficiary files a timely request for fair hearing pursuant to Subsection (a).

(c) For the purpose of this Section, each reference to Medi-Cal managed care plan in Title 22, Section 51014.2, shall mean the MHP.

(d) Before requesting a state fair hearing, the beneficiary must exhaust the MHP's problem resolution processes as described in Section 1850.205.

§ 1850.305. General Provisions.

(a) An MHP shall develop provider problem resolution and appeal processes that enable providers to resolve MHP payment authorization issues or other complaints and concerns. The MHP shall not subject a provider to discrimination or any other penalty for using the provider problem resolution and appeal processes.

(b) The MHP shall ensure that participating providers are provided written information regarding the provider problem resolution and appeal processes.

§ 1850.310. Provider Problem Resolution Process.

The Provider Problem Resolution Process shall, at a minimum:

(a) Include a means to accept written or verbal concerns or complaints from providers and address these concerns or complaints quickly and easily.

(b) Utilize simple, informal, and easily understood procedures.

(c) Inform providers of their right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP and whether accessing the Provider Problem Resolution Process will affect the provider's timelines for accessing the Provider Appeal Process.

§ 1850.315. Provider Appeal Process.

The Provider Appeal Process shall include the following:

(a) A provider may appeal a denied or modified request for MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to the MHP within 90 calendar days of the date of receipt of the non-approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the time frames required by Sections 1820.220 or 1830.250, or established by the MHP pursuant to Section 1830.215.

(b) The MHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

(1) If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

(2) If the appeal is not granted in full, the provider shall be notified of any right to submit an appeal to the Department pursuant to Section 1850.320.

(3) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

(4) If applicable, the MHP shall have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the documentation to the Medi-Cal fiscal intermediary that is required to process the MHP payment authorization.

(c) If an MHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by the MHP.

§ 1850.320. Provider Appeals to the Department.

When an appeal concerning the denial or modification of an MHP payment authorization request for the specialty mental health services provided in an emergency as described in Sections 1820.225, 1830.230, and 1830.245 is denied in full or in part by the MHP's Provider Appeal Process on the basis that the provider did not comply with the required timelines for notification or submission of the MHP payment request, that the medical necessity criteria were not met, or that the requirements of Section 1820.220(j)(5) for approval of administrative days were not met, the provider may appeal the denial or modification to the Department. A hospital may not appeal the denial or modification of MHP payment authorization to the Department when the denial or modification is based on the MHP's determination that a hospital has failed to comply with mandatory provisions of the contract between the provider and the MHP as allowed by Sections 1820.220(g), (j) and 1820.225(d)(5).

(a) Hospitals and the individual, group or organizational providers who have provided specialty mental health services under Sections 1820.225, 1830.230, and 1830.245 to a beneficiary during the psychiatric inpatient hospital stay that is the subject of the appeal may appeal separately to the Department unless they have agreed to another arrangement as a term of their contract with the MHP.

(b) If a provider chooses to appeal an MHP's denial or modification of MHP payment authorization, the provider shall submit an appeal to the Department in writing, along with supporting documentation, within 30 calendar days from the date the MHP's written decision of denial or modification is submitted to the provider. The provider may appeal to the Department within 30 calendar days after 60 calendar days from submission of the appeal under Section 1850.315(a) to the MHP, if the MHP fails to respond. Supporting documentation shall include, but not be limited to:

(1) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

(2) Clinical records supporting the existence of medical necessity if at issue.

(3) A summary of reasons why the MHP should have approved the MHP payment authorization.

(4) A contact person(s) name, address and phone number.

(c) The Department shall notify the MHP and the provider of its receipt of a request for appeal pursuant to this Section within seven calendar days from the date of receipt of the request. The notice to the MHP shall include a request to the MHP for specific documentation supporting denial of the MHP payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal pursuant to Subsection (a).

(d) The MHP shall submit the requested documentation within 21 calendar days of the date the notice to the MHP from the Department pursuant to Subsection (c) was received by the MHP or the Department shall decide the appeal based solely on the documentation filed by the provider.

(e) The Department shall have 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation was received by the MHP, whichever is earlier, to notify the provider and the MHP, in writing, of its decision, including a statement of the reasons for the decision that addresses each issue raised by the provider and the MHP, and any actions required by the MHP or the provider to implement the decision. At the election of the provider, if the Department fails to act within the 60 calendar days, the appeal may be considered to have been denied by the Department.

(1) The Department may allow both a provider representative(s) and the MHP representative(s) an opportunity to present oral argument to the Department.

(2) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the Department's decision to uphold the appeal.

(3) If applicable, the MHP shall have 14 calendar days from the receipt of the provider's revised MHP payment authorization request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.

§ 1850.325. Provider Appeal Process - Claims Processing.

Notwithstanding Sections 1850.305-1850.320:

(a) A Fee-for-Service/Medi-Cal hospital or a psychiatric nursing facility may file an appeal concerning the processing or payment of its claims for payment for services directly to the fiscal intermediary postmarked or FAXED within 90 calendar days of the date the payment was due. The fiscal intermediary shall have 60 calendar days from the receipt of the appeal to make a determination in writing to the provider.

(b) An MHP may file an appeal concerning the processing or payment of its claim for services paid through the Short-Doyle/Medi-Cal system to the Department postmarked or FAXED within 90 calendar days of the date the payment was due. The Department shall have 60 calendar days from the receipt of the appeal to make a determination in writing to the MHP.

§ 1850.350. MHP/MHP Subcontractor Client Record Review Findings Appeal Process.

(a) MHP and MHP subcontractor appeals process

(1) The appeal process consists of:

(A) An informal appeal process as specified in section 1850.350 (b).

(B) A formal appeal process.

(2) The appeal process may only be used for disallowances of paid claims resulting from client record review findings,

(b) The informal appeal shall be conducted by a Department review officer to clarify or resolve facts and issues in dispute.

(1) An informal appeal request by an MHP or MHP subcontractor shall be made in writing to the Department within 60 calendar days following the receipt of the client record review findings in dispute.

(2) The informal appeal request shall include:

(A) Written documentation supporting the rationale for the informal appeal for each disallowance in dispute.

(B) Other supporting information and/or material to be considered by the Department.

(C) A contact name, phone number and address.

(D) A statement of whether the MHP or MHP subcontractor requests that a decision be made solely upon the written documentation submitted or in conjunction with a telephone or face-to-face conference.

(3) If an MHP subcontractor is requesting the informal appeal, the MHP subcontractor shall notify the MHP at the same time of filing the request with the Department by sending the MHP:

(A) A copy of the request

(B) Complete documentation supporting the rationale for the appeal.

(4) If an MHP is requesting an informal appeal regarding a matter involving an MHP subcontractor, the MHP shall notify the MHP subcontractor at the same time of filing the request with the Department by sending the MHP subcontractor:

(A) A copy of the request

(B) Complete documentation supporting the rationale for the appeal.

(5) The Department shall render the informal appeal decision in writing based on the information provided within 30 calendar days:

(A) Of receipt of the informal appeal request if the MHP or MHP subcontractor has requested a decision based solely on the written documentation submitted. The date of receipt shall be the date stamped as received by the Department.

or

(B) Of conclusion of the telephone or face-to-face conference, if requested.

(6) Decisions rendered are considered final unless a formal appeal is requested by the entity initiating the informal appeal.

(c) A request for a formal appeal shall be filed, with the State Agency indicated in the informal appeal decision notification, within 30 calendar days of the date of issuance of the decision.

(1) Requests for formal appeal may only be filed after the Department of Mental Health has issued a written decision regarding an informal appeal on the same matter.

(2) Requests for a formal appeal may only be filed by the entity that initiated the informal appeal.

(3) At the same time as specified in section (c), a copy of the request shall be provided by the appellant to the following:

(A) The Department of Mental Health.

(B) The MHP, if an MHP subcontractor is requesting the formal appeal.

(C) The MHP subcontractor, if an MHP is requesting the formal appeal regarding a matter involving an MHP subcontractor.

§ 1850.405. Arbitration Between MHPs.

(a) Under the following arbitration processes the MHP of the beneficiary may be determined to be different than that specified in the MEDS file.

(b) Any two or more MHPs may develop an arbitration agreement to provide for determining final responsibility for MHP payment authorization as described in Subchapters 2 and 3, beginning with Sections 1820.100 and 1830.100, respectively, when there is a dispute between the participating MHPs. Each arbitration agreement must:

(1) Provide for the selection of an arbitrator.

(2) Include timelines for filing and resolution.

(3) Include criteria that will serve as a basis for a decision.

(4) Specify that decisions reached under the arbitration process will be final.

(5) Be signed by all participating MHPs or their designees.

(6) Require that all decisions of the arbitrator shall be in writing.

(7) Provide that a copy of each decision shall be forwarded to the affected MHPs within 14 calendar days of the decision.

(c) In cases where there is a disagreement between MHPs that are not participating in an arbitration process, the arbitration process shall be as follows:

(1) Each MHP shall provide the Department with at least one individual available to serve as an arbitrator. The MHP shall confirm or update the available individuals annually. The Department shall provide a listing of the available individuals to the MHPs annually by October 1. The parties to the dispute may agree to a single arbitrator. If the parties to the dispute cannot agree on a single arbitrator, the parties shall each select an arbitrator from the list of available individuals, except that an individual identified by either involved MHP may not be selected. The selected arbitrators shall select a third arbitrator who is not an individual identified by either involved MHP from the listing.

(2) The arbitrators' services shall be reimbursed at the hourly rate charge of \$150.00, not to exceed a total of ten hours. The parties shall share equally in paying for the arbitrators' services. Payment shall be made directly to the arbitrators unless the arbitrator is an employee of the MHP, in which case payment shall be made to that MHP.

(3) The arbitrators' decision as to the MHP of the beneficiary shall be based on a review of the facts in relation to the following criteria:

(A) If a beneficiary has moved to a county or acts to establish residency in a county and has a clear intent to reside in the county, the MHP for that county shall be considered the MHP of the beneficiary.

(B) If a beneficiary is a Lanterman-Petris-Short or Probate Conservatee, the MHP for the county in which the beneficiary is conserved shall be considered the MHP of the beneficiary.

(C) If a beneficiary has been placed in legal custody by a county, the MHP for the county that initiated the legal proceeding shall be considered the MHP of the beneficiary. If a beneficiary is on parole or in a conditional release program and is restricted to a particular area, the MHP for the county that includes the area to which the beneficiary is restricted shall be the MHP of the beneficiary.

(D) If a beneficiary has adopted a transient, nomadic lifestyle and has a clear intent to continue this lifestyle, the MHP for the county in which the beneficiary presents for services shall be considered the MHP of the beneficiary.

(E) If a beneficiary, because of the beneficiary's mental status, is unable to form or express a clear intent to reside anywhere, the following may be considered evidence that the MHP for the county involved would be the MHP of the beneficiary:

1. The county that originated residential, medical, or psychiatric placement.

2. The county in which the beneficiary has current housing.
3. The county that has paid general assistance to the beneficiary.
4. The county in which the beneficiary has received ongoing community mental health clinical care during the last six months.

(F) Where the facts do not clearly meet the criteria, the arbitrators' decision shall be reasonable in light of the facts presented using the criteria in Subsections (a)(3)(A)-(E) as general guidelines.

(4) The affected MHPs shall provide relevant documentation to arbitrators no later than 21 calendar days after the arbitrators have been selected.

(5) The arbitrators shall decide on the issue no later than 60 calendar days:

(A) From the date documentation is received from the affected MHPs, or

(B) From 21 calendar days after the arbitrator has been selected, whichever is sooner.

(6) The arbitrators shall issue the decision in writing to the affected MHPs within 14 calendar days of the decision.

§ 1850.415. Implementation of the Arbitrators' Decision.

When the arbitrators acting under Section 1850.405 determine that an MHP is responsible for payment for specialty mental health services previously authorized by another MHP, the MHP found responsible for payment of services shall perform, within 14 calendar days from the date of the arbitrator's decision, any action required of the MHP to implement the decision of the arbitration process. The Department reserves the right to take action necessary to implement the decision of the arbitration process if the MHP found to be responsible fails to comply with the decision.

§ 1850.420. Provision of Medically Necessary Services Pending Resolution of Dispute.

A dispute regarding the MHP of the beneficiary shall not delay medically necessary services to beneficiaries. The MHP of the beneficiary as identified on the MEDS file shall be responsible for providing or authorizing and paying for the service until the dispute is resolved.

§ 1850.505. Requests for Resolution.

(a) Except as provided in Subsection (c), when an MHP has a dispute with a Medi-Cal Managed Care Plan that cannot be resolved to the satisfaction of the MHP concerning the obligations of the MHP or the Medi-Cal Managed Care Plan under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the MHP may submit a request for resolution to the Department.

(b) Except as provided in Subsection (c), when a Medi-Cal Managed Care plan has a dispute with an MHP that cannot be resolved to the satisfaction of the Medi-Cal Managed Care Plan concerning the obligations of the MHP or the Medi-Cal Managed

Care Plan under their respective contracts with the State, State Medi-Cal laws and regulations, or an MOU as described in Section 1810.370, the Medi-Cal Managed Care Plan may submit a request for resolution to the State Department of Health Services.

(c) If the MHP and the Medi-Cal managed care plan have agreed in the MOU entered into pursuant to Section 1810.370 to binding arbitration as the means for resolving disputes, the MHP and the Medi-Cal managed care plan may not request resolution of the dispute under this Section.

(d) If the MHP and the Medi-Cal Managed Care Plan have an MOU pursuant to Section 1810.370, a request for resolution by either department shall be submitted to the respective department within 15 calendar days of the completion of the dispute resolution process between the parties as provided in the MOU. If there is no MOU, a request for resolution shall be submitted to the respective department within 30 calendar days after the event giving rise to the dispute. The request for resolution shall contain the following information:

(1) A summary of the issue and a statement of the desired remedy, including any disputed services that have been or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service.

(2) History of attempts to resolve the issue.

(3) Justification for the desired remedy.

(4) Documentation regarding the issue.

(e) Upon receipt of a request for resolution, the department receiving the request shall notify the other department and the other party within seven calendar days. The notice to the other party shall include a copy of the request and will ask for a statement of the party's position on the dispute, any relevant documentation supporting its position, and any dispute of the rate of payment for services included by the other party in its request.

(f) The other party shall submit the requested documentation within 21 calendar days from notification of the party from whom documentation is being requested by the party that received the initial request for resolution or the departments shall decide the dispute based solely on the documentation filed by the initiating party.

§ 1850.515. Departments' Responsibility for Review of Disputes.

(a) The two departments shall each designate at least one and no more than two individuals to review the dispute and make a joint recommendation to directors of the departments or their designees.

(b) The recommendation shall be based on a review of the submitted documentation in relation to the statutory, regulatory and contractual obligations of the MHP and the Medi-Cal Managed Care Plan.

(c) The individuals reviewing the dispute may, at their discretion, allow representatives of both the MHP and the Medi-Cal Managed Care Plan an opportunity to present oral argument.

§ 1850.520. Departments' Decision.

(a) The Directors of the departments or their designees shall jointly issue a written decision to the MHP and the Medi-Cal Managed Care Plan within 30 calendar days:

- (1) From the receipt of the documentation requested from the other party, or
- (2) From the twenty-first calendar day after the request for documentation, whichever is earlier.

(b) The written decision of the departments shall include a statement of the reasons for the decision, the determination of rates of payment if the rates of payment were disputed, and any decision and any actions required by the MHP and the Medi-Cal Managed Care Plan to implement the decision.

(c) The departments shall take any necessary steps to enforce the decision, including the withholding of funds to meet any financial liability established pursuant to Section 1850.530.

§ 1850.525. Provision of Medically Necessary Services Pending Resolution of Dispute.

A dispute between an MHP and a Medi-Cal Managed Care Plan shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries. Until the dispute is resolved, the following shall apply:

(a) The parties may agree to an arrangement satisfactory to both parties regarding how the services under dispute will be provided; or

(b) When the dispute concerns the Medi-Cal Managed Care Plan's contention that the MHP is required to deliver specialty mental health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the MHP, the Medi-Cal Managed Care Plan shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved. The MHP shall identify and provide the Medi-Cal managed care plan with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi-Cal managed care plan provider responsible for the beneficiary's care.

(c) When the dispute concerns the MHP's contention that the Medi-Cal Managed Care Plan is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved.

§ 1850.530. Financial Liability.

(a) When the resolution of a dispute under this Article includes a determination that the unsuccessful party in the dispute has a financial liability to the other party for services rendered by the successful party, financial liability and the liquidation of that liability shall follow the criteria of Subsections (b)-(d).

(b) Unless determined otherwise as provided in Subsection (c), financial liability shall not exceed the lower of the following rates, in effect at the time the services were rendered:

(1) The usual and customary charges made to the general public by the provider who rendered the service.

(2) The fee-for-service rates for similar services under the Medi-Cal program. Upon determination of the financial liability, if no final rate has been established for the providers who rendered the services for the period and type of services in question, then the applicable interim rate shall be used for the final determination of financial liability.

(c) The rate of payment included in the request pursuant to Section 1850.505(d)(1) shall be presumed correct, and the successful party shall be entitled to the full rate requested in its request should it prevail, unless the other party disputed the rate of payment in its response under Section 1850.505(e), which places the rates in issue.

(d) A plan determined to be financially liable shall within 30 calendar days of the effective date of the decision:

(1) Reimburse the successful party for the full amount of the determined liability.

(2) Provide proof of reimbursement in such form as the written decision of the departments requires.

§ 1850.535. Additional Conditions of the Dispute Resolution Process.

(a) Nothing in this Article shall preclude the departments from taking oversight/corrective actions against their respective plans.

(b) Nothing in this Article shall preclude a beneficiary from utilizing the MHP's beneficiary problem resolution process or any similar process offered by the Medi-Cal managed care plan or to request a fair hearing. When there is a conflict between a fair hearing decision and a decision by the departments under this Article, the fair hearing decision shall take precedence.

§ 35325. Request for Adoption Assistance.

(a) The Adoption Assistance Program (AAP) removes or reduces barriers to the adoption of children who otherwise would remain in long-term foster care. The program provides necessary financial assistance to families who are willing and able to assume parental responsibility for children but are prevented from doing so by inadequate financial resources.

(b) The agency shall provide any person who wants to apply for adoption assistance benefits with a Request for Adoption Assistance form (AAP 1).

(1) If the agency placing a child for adoption believes the child to be an AAP-eligible child, the agency shall offer the family an AAP 1.

(c) The responsible public agency refers to the department or licensed county adoption agency responsible for determining a child's AAP eligibility and initial and subsequent payment amounts. The income maintenance division of each county welfare department is responsible for federal eligibility determination and payment of AAP benefits.

(1) If the child has been voluntarily relinquished for adoption to a California licensed public or private adoption agency and placed with a California prospective adoptive family, the financially responsible county shall be the county in which the relinquishing parent resides. The prospective adoptive parents shall submit the completed AAP 1 and supporting documentation to the responsible public agency representing their county of residence.

(A) The licensed private adoption agency shall submit the AAP 1 and supporting documentation, including, but not limited to, the assessment of the child required by Section 35127.1 and a description of efforts to locate a non-subsidy home for the child, as the Department or licensed county adoption agency finds necessary in the particular case.

(2) If a child is relinquished to a private adoption agency in another state and placed with a prospective adoptive family in California, the prospective adoptive family's county of residence is financially responsible. The prospective adoptive parents shall submit the completed AAP 1 and supporting documentation to the responsible public agency representing their county of residence.

(3) If a child is relinquished to a private adoption agency in California and placed with a prospective adoptive family in another state, the public child welfare agency in the adoptive parents' state of residence is responsible for determining the child's eligibility and for all AAP payments.

(d) Once established, the county of responsibility shall remain unchanged for the duration of adoption assistance payments for that child.

(e) The responsible public agency shall determine whether the child meets the eligibility requirements as specified in Section 35326.

(1) If an AAP 1 is submitted on behalf of a relinquished child who is not under the supervision of a county welfare department as the subject of a legal guardianship or a juvenile court dependency, the agency shall ask that entity responsible for providing services to children who are dependents of the court in the county that would be responsible for providing AAP benefits for a written determination as to whether the child would or would not have been at risk of dependency if the child had not been relinquished for adoption.

(2) If the responsible public agency determines that the child is not eligible for AAP benefits, the agency shall send the county responsible for payment a completed Payment Instructions - Adoption Assistance Program form (AAP 2) indicating that AAP eligibility is denied and the specific reason(s), including relevant regulatory or statutory citations, for the denial.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 16118, 16119, 16120 and 16121, Welfare and Institutions Code; 45 CFR 1356.40; and 42 USC 673 and 675.

HISTORY

1. Renumbering of former article 1 to article 2, renumbering of former section 35325 to section 35326, and new article 1 and section filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 91, No. 52.
2. Certificate of Compliance as to 10-31-94 order including amendment of subsections (a) and (b)(1), new subsection (e)(3)(E) and subsection relettering transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).
3. Amendment of subsection (e)(3)(C)1. filed 5-3-99; operative 5-3-99 (Register 99, No. 19).
4. New subsection (c)(2)(A), subsection relettering, amendment of subsection (e)(3)(D), new subsection (e)(3)(D)5. and amendment of Note filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.
5. New subsection (c)(2)(A), subsection relettering, amendment of subsection (e)(3)(D), new subsection (e)(3)(D)5. and amendment of Note refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 3-31-2001 order, including further amendment of subsection (c)(2)(B) and new subsection (d) reference, transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).
7. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35326. AAP Eligibility.

To be eligible for Adoption Assistance Program (AAP) benefits, the child must be under the age of 18 and meet the three part special needs determination, citizenship requirements, and Title IV-E (federal) funding requirements or state funding requirements specified in Welfare and Institutions Code Section 16120.

(a) The three-part special needs determination requires ALL of the following three conditions be met:

(1) Evidence in the file that the child cannot or should not be returned to the home of his or her parents.

(A) Sufficient evidence includes a petition to terminate parental rights, a court order terminating parental rights, a signed relinquishment or a tribal customary adoption order.

(2) A specific factor or condition makes it reasonable to conclude that the child cannot be adopted without providing AAP payments.

(A) Factors or conditions include a child's ethnic background, age or membership in a minority or sibling group, parental background of a medical or behavioral nature that can adversely affect the development of the child, the presence of a medical condition, or physical, mental or emotional disabilities.

(3) An effort to place the child for adoption with appropriate parents without providing adoption assistance unless it is against the best interest of the child.

(A) This search for adoptive parents shall be documented in the adoption case record and include the following:

1. A discussion of potential adoptive parents at a regional adoption agency exchange meeting, or
2. Registration of the child with the department's photo-listing album.

(B) A child who develops significant emotional ties with the prospective adoptive parents while in their care as a foster child or if a relative is adopting a child, then it would be in the child's best interest to remain with them and additional efforts to place the child are not required.

1. This search shall not be required when the current foster parents, or other persons with whom the child has been living and has established significant emotional ties, have both:

- a. Expressed interest in adopting the child, and
- b. Been determined by the agency to be suitable adoptive parents for the child.

(b) The child must be a United States citizen or a qualified alien as defined in Title 8 USC section 1641(b).

(1) If a child is placed with an unqualified alien, the child must be a qualified alien or have lived in the U.S. for five years, if the child entered the United States on or after August 22, 1996.

(2) The child is exempt from the five year residency requirement if the child is placed with a U.S. citizen or qualified alien, or the child is a member of one of the excepted groups pursuant to Title 8 USC section 1612(b): refugees, asylees, aliens whose deportation is withheld, veterans and those on active duty (as well as the spouse and unmarried dependent children of that person), Cuban or Haitian entrants and Amerasians from Vietnam.

(3) If a child is an unqualified alien and placed outside the United States, the county may use county funds to cover the AAP costs for an otherwise AAP eligible child.

(c) To be eligible for Title IV-E (federal) funding, one of the following five paths to eligibility OR the definition of an "Applicable Child" and one of the four corresponding eligibility paths must be met:

(1) At the time the child was removed from the home of a specified relative, the child would have been Aid to Families with Dependent Children (AFDC)-eligible in the home of removal according to July 16, 1996 AFDC standards.

(A) In an involuntary situation, when a child's removal from the home is the result of a court action, there must also be a judicial determination that to remain in the home would be contrary to the child's welfare.

1. The determination must be made in the first court ruling (minute order) that sanctions (even temporarily) the removal.

2 The "contrary to the welfare" finding must be explicit in the first court order.

(B) For children voluntarily relinquished to a licensed public or private adoption agency, or another public agency operating a Title IV-E program on behalf of the state (Tribes), the following must be obtained within six months of the time the child lived with a specified relative:

1. A petition to the court to remove the child from the home of a specified relative within six months of the date the child lived with the relative; and

2. Subsequent judicial determination that remaining in the home would be contrary to the child's welfare.

(C) In the case of a voluntary placement agreement between the child's parent/legal guardian and the county agency, at least one Title IV-E foster care maintenance payment must have been made on behalf of the child.

(2) At least one Title IV-E foster care maintenance payment has been made on behalf of the child's minor parent to cover the cost of the minor parent's child while in the foster parent's home or child care institution with the minor parent.

(3) A child received AAP benefits with respect to a prior adoption, the prior adoption dissolved, and the child is again available for adoption. To remain eligible the child must meet the following:

(A) Three part special needs determination

(B) Citizenship requirements

(4) Prior to the finalization of an agency adoption or an independent adoption, the child has met the requirements to receive federal Supplemental Security Income (SSI) benefits as determined and documented by the federal Social Security Administration (SSA).

(5) The child is an Indian child and the subject of an order of adoption based on tribal customary adoption of an Indian child, as described in Welfare and Institutions Code Section 366.24.

(d) An “applicable child” is a child who:

(1) Has been in foster care for at least 60 consecutive months, or

(2) Is a sibling of an “applicable child,” if both are placed in the same prospective adoptive home, or

(3) Meets the applicable age requirement anytime before the end of the Federal Fiscal Year (FFY).

(A) FFY is October 1st through September 30th.

(B) A child who has or will attain the stated age or is older than the stated age in (d)(3)(B)(1) through (d)(3)(B)(8) by the end of the corresponding current FFY is considered to be an “applicable child”:

(1) In FFY 2010, the applicable age is 16 years.

(2) In FFY 2011, the applicable age is 14 years.

(3) In FFY 2012, the applicable age is 12 years.

(4) In FFY 2013, the applicable age is 10 years.

(5) In FFY 2014, the applicable age is 8 years.

(6) In FFY 2015, the applicable age is 6 years.

(7) In FFY 2016, the applicable age is 4 years.

(8) In FFY 2017, the applicable age is 2 years or younger.

(e) The “applicable child” must meet one of the four eligibility paths:

(1) The child is in the care of a public or private child placement agency or Indian tribal organization and is the subject of either one of the following:

(A) An involuntary removal from the home in accordance with a judicial determination that continuation in the home would be contrary to the welfare of the child;

(B) A voluntary placement agreement or voluntary relinquishment.

1. A Title IV-E foster care maintenance payment does not have to be made on behalf of an “applicable child,” or

2. Judicial determination that continuation in the home would be contrary to the welfare of the child.

(2) The child has met all medical or disability eligibility requirements for federal supplemental security income (SSI) benefits.

(3) The child was residing in a foster family home or child care institution with the child's minor parent.

(4) The child received AAP with respect to a prior adoption that dissolved.

(f) To be eligible for State funding, the child is the subject of an agency adoption and at the time of adoptive placement, the child met one of the following requirements:

(1) Under the supervision of a county welfare department as the subject of a legal guardianship or juvenile court dependency.

(2) Relinquished to a licensed California private or public adoption agency, or another public agency operating a Title IV-E program on behalf of the state, and would have otherwise been at risk of dependency as certified by the responsible public child welfare agency.

(3) Committed to the care of the department or county adoption agency pursuant Family Code Sections 8805 or 8918.

(g) There shall be no means test used to determine AAP eligibility.

(h) The prospective adoptive parent and any other adult living in the prospective adoptive home has completed the criminal background check requirements pursuant to Title 42 USC Section 671(a)(20)(A) and (C).

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Sections 16118, 16119, 16120 and 16121.05, Welfare and Institutions Code; 42 USC 671 and 673; and 45 CFR 1356.40(c).

HISTORY

1. Renumbering of former article 1 to article 2, and renumbering and amendment of former section 35325 to section 35326 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 10-31-94 order including amendment of subsection (b) transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Amendment of subsection (a), new subsection (b) and subsection relettering filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

4. Amendment of subsection (a), new subsection (b) and subsection relettering refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 3-31-2001 order transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

6. Repealer and new section and amendment of Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35327. Search for Parents Not Requiring Adoption Assistance. [Repealed]

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code. Reference: Sections 16118 and 16120, Welfare and Institutions Code; and 42 USC 671 and 673.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Repealer filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35329. Effect of Adoptive Parent's Legal Residence.

(a) The adoptive parent's legal residence shall not affect the child's eligibility specified by Welfare and Institutions Code Section 16121.1.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code; and Section 8621, Family Code. Reference: Sections 16118, 16120 and 16121.1, Welfare and Institutions Code; 42 U.S.C. 671 and 673; and 45 CFR 1356.40(d) and (e).

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Change without regulatory effect amending Note filed 3-27-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 13).

3. Amendment of subsection (a) and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35331. Documentation of Child's Eligibility.

(a) The determination of the child's eligibility for adoption assistance shall be documented in the case record on the Eligibility Certification - Adoption Assistance

Program form (AAP 4) and the Federal Eligibility Certification for Adoption Assistance Program (FC 8).

(1) The agency shall submit the Federal Eligibility Certification for Adoption Assistance Program form (FC 8) to the county responsible for payment.

A. The child's birth name shall be used on the FC 8.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code.
Reference: Sections 16118 and 16120, Welfare and Institutions Code; and 42 USC 671 and 673.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.
2. Designation and amendment of subsection (a) filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10-31-94 order transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).
4. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35332. Notification Requirements for Agencies. [Renumbered]

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Sections 16119 and 16120, Welfare and Institutions Code; and 45 CFR 1356.41(e).

HISTORY

1. New section filed 1-8-90 as an emergency; operative 1-8-90 (Register 90, No. 9). A Certificate of Compliance must be transmitted to OAL within 120 days, by 5-8-90, or emergency language will be repealed on 5-9-90.
2. Certificate of Compliance as to 1-8-90 order transmitted to OAL 5-4-90 and filed 6-4-90 (Register 90, No. 30).
3. Renumbering of former section 35332 to new section 35352 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

§ 35332.1. Eligibility for Reimbursement. [Renumbered]

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Section 16120.1, Welfare and Institutions Code; and 45 CFR 1356.41.

HISTORY

1. New section filed 1-8-90 as an emergency; operative 1-8-90 (Register 90, No. 9). A Certificate of Compliance must be transmitted to OAL within 120 days, by 5-8-90, or emergency language will be repealed on 5-9-90.
2. Certificate of Compliance as to 1-8-90 order transmitted to OAL 5-4-90 and filed 6-4-90 (Register 90, No. 30).
3. Renumbering of former section 35332.1 to new section 35352.1 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

§ 35332.2. Authorization for Reimbursement. [Renumbered]

Note: Authority cited: Sections 10553, 10554 and 16120(a), Welfare and Institutions Code. Reference: Section 16120.1, Welfare and Institutions Code; and 45 CFR 1356.41(g).

HISTORY

1. New section filed 1-8-90 as an emergency; operative 1-8-90 (Register 90, No. 9). A Certificate of Compliance must be transmitted to OAL within 120 days, by 5-8-90, or emergency language will be repealed on 5-9-90.
2. Certificate of Compliance as to 1-8-90 order transmitted to OAL 5-4-90 and filed 6-4-90 (Register 90, No. 30).
3. Renumbering of former section 35332.2 to new section 35352.2 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

§ 35332.3. Agency Requirements for Reimbursements. [Renumbered]

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code. Reference: Section 16120.1, Welfare and Institutions Code.

HISTORY

1. New section filed 1-8-90 as an emergency; operative 1-8-90 (Register 90, No. 9). A Certificate of Compliance must be transmitted to OAL within 120 days, by 5-8-90, or emergency language will be repealed on 5-9-90.
2. Certificate of Compliance as to 1-8-90 order transmitted to OAL 5-4-90 and filed 6-4-90 (Register 90, No. 30).

3. Renumbering of former section 35332.3 to new section 35352.3 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

§ 35333. Determination of Amount and Duration of AAP Benefit for All Children.

The Adoption Assistance Program (AAP) provides benefits to facilitate the adoption of children who otherwise would not likely be adopted. The AAP benefit is a negotiated amount based upon the needs of the child and the circumstances of the adoptive family. The responsible public agency and the prospective adoptive parent(s) shall negotiate and agree on the amount of the AAP benefit according to the requirements of this section.

(a) The responsible public agency shall make a good faith effort to negotiate the AAP benefit with the adoptive parents.

(1) The agency shall encourage the adoptive parents to request the AAP benefit they require in order to meet the child's needs taking into account their family circumstances.

(2) The agency shall base the negotiated AAP benefit on the needs of the child and the circumstances of the family determined through discussion with the adoptive parents.

(A) The agency shall advise the adoptive parents that the amount of the AAP benefit determined for the child is limited to the age-related, state-approved foster family home rate and any applicable state-approved specialized care increment for which the child is eligible.

(3) There shall be no use of a means test of the child or the adoptive parent when determining the AAP benefit amount.

(4) The amount of the negotiated AAP benefit shall be between zero and the maximum AAP benefit for which the child is eligible.

(5) The agency shall advise the adoptive parents that the AAP benefit does not include payment for any specific good or service, but is intended to assist the adoptive parents in meeting the child's needs.

(b) The responsible public agency, after consultation with the adoptive parents and the financially responsible county, if different from the agency, shall identify the child's care and supervision needs, including any special needs beyond basic care and supervision.

(1) The adoption caseworker shall base the assessment of the child's needs and required level of care and supervision on all of the following information:

(A) Direct observation of the child.

(B) Information contained in the child's case record, including birth history and psychological, medical and other relevant assessments completed by licensed professionals.

(C) Information about the child based on application of the county's foster care specialized care assessment instrument or any specialized foster care increment previously approved for the child.

(D) Information provided by the adoptive parents.

(c) The responsible public agency in consultation with the financially responsible county, if different from the agency, shall determine the maximum state-approved foster care maintenance payment that the child would have received in a foster family home if the child had remained in foster care.

(1) No agency may use a Foster Family Agency (FFA) treatment rate or a payment made to a certified home by a FFA on behalf of the child for purposes of calculating the maximum AAP benefit for which the child is eligible.

(A) If a child continues to require the additional services provided by the FFA, the adoptive placement shall continue to be funded by foster care payments rather than by AAP benefits until the AAP agreement is executed.

(2) If the child is living in the adoptive family's home, the agency shall assume that, but for adoptive placement, the child would be living in a licensed foster family home.

(A) If the child is placed for adoption within the financially responsible county, the AAP benefit shall not exceed the age-related, state-approved foster family home care rate, for which the child would otherwise be eligible.

(B) If the child is placed for adoption in California but outside the financially responsible county, the AAP benefit shall not exceed the age-related, state-approved foster family home care rate of the financially responsible county or that of the host county, whichever is higher, for which the child would otherwise be eligible.

(C) If the child is placed for adoption outside California, the AAP benefit shall not exceed the applicable California age-related, state-approved foster family home care rate or the applicable rate in the host state, whichever is higher, for which the child would otherwise be eligible.

(D) If the child also has any special needs which would qualify him or her for a specialized care increment (SCI), the AAP benefit shall include the applicable state-approved SCI in addition to the age-related, state-approved foster family home rate.

1. If the child requires a benefit based on a special need in addition to age-related state-approved foster family home rate, the agency shall document each special need by describing the need including the underlying problem or condition.

2. Specialized care provides a supplemental payment to a caregiver, in addition to the state-approved foster family home care rate, for the cost of supervision (and the cost of providing that supervision) to meet the additional daily care needs of a child who has a health or behavior problem.

3. If the child is placed for adoption outside the financially responsible county, the agency shall use the specialized care rate of the host county or that of the financially

responsible county, whichever is higher, or that of the financially responsible county when the host county has no specialized care system.

(3) If the child is a client of a California Regional Center (CRC) for the Developmentally Disabled, the maximum rate shall be pursuant to Welfare and Institutions Code Section 16121(c). Dual agency children who leave California shall be able to continue to receive AAP benefits reflected in the last AAP agreement signed prior to leaving California.

(4) If the child is temporarily living away from the adoptive home and the AAP benefit is not authorized under Section 35334(a) or Section 35334(c), the agency shall consider the child to be living in the adoptive home.

(5) The adoptive parents shall provide a written statement on the form AAP 1 explaining how they plan to incorporate the adoptive child into their family and the impact, if any, on their family's lifestyle and circumstances.

(6) "Circumstances of the Family" means circumstances of the family as defined in Welfare and Institutions Code Section 16119(d)(2).

(A) The agency should not control or participate in the adoptive family's choices regarding their lifestyle, standard of living, or future plans.

(d) The agency shall complete the Adoption Assistance Program Negotiated Benefit Amount and Approval Form (AAP 6) and file in the child's AAP file.

(1) When only age-related state-approved foster family home rate is requested by the family, the agency shall include a statement to that effect for retention in the child's AAP file.

(e) When agreement on the AAP benefit has been reached, the responsible public agency shall complete an Adoption Assistance Agreement (AD 4320) with the adoptive parents.

(1) The agency shall complete the AAP 2 instructing the county to send a Notice of Action to the adoptive parents indicating that the AAP benefit is approved.

(2) After completion of the Adoption Assistance Agreement (AD 4320), the adoptive parents shall have the right to use the AAP benefit to meet the child's needs as they deem appropriate without further agency approval.

(f) When the responsible public agency and the adoptive parents are unable to agree on an AAP benefit, the agency shall complete the AAP 2 instructing the county to send the adoptive parents a Notice of Action that the requested AAP benefit is denied. The agency shall specify the reason for denial.

(1) If the adoptive parent does not agree on the AAP benefit, the parent may request a state hearing as instructed in the Notice of Action pursuant to MPP Section 22-004.

(g) A reassessment of the AAP benefit shall be required every two (2) years beginning from the date of a signed Adoption Assistance Program Agreement (AD 4320) between the agency and the adoptive parents.

(1) Once a child is determined eligible to receive AAP, he or she remains eligible and the subsidy continues unless one of the following occurs:

(A) The child has attained the age of 18 or 21;

1. Payment of the AAP benefit shall terminate in the month in which the child becomes 18 years of age or if the agency has determined that the child has a mental or physical disability that warrants the continuance of assistance, in the month in which the child becomes 21 years of age.

a. Starting January 1, 2012, youth who have an initial AAP agreement signed on or after their 16th birthday and who meet the conditions stated in Welfare and Institutions Code Section 11403, may be eligible for the extension of AAP benefits to the age of 19, the age of 20 effective January 1, 2013, and the age of 21 effective January 1, 2014.

(B) The adoptive parents are no longer legally responsible for the support of the child.

(C) The responsible public agency determines the adoptive parents are no longer providing support to the child.

Note: Authority cited: Sections 10553, 10554 and 16118, Welfare and Institutions Code. Reference: Sections 11405, 16118, 16119, 16120, 16120.05, 16121 and 16121.05, Welfare and Institutions Code; 45 CFR 1356.40; and 42 USC 673 and 675.

HISTORY

1. Repealer of article 2 and section and new article 3 and section filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day. For prior history, see Register 88, No. 50.

2. Certificate of Compliance as to 10-31-94 order including amendment of section and Note transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Repealer and new section filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

4. Repealer and new section refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 3-31-2001 order, including further amendment of section, transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

6. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35334. AAP Benefits for a Child in Temporary Out-of-Home Placement.

(a) The responsible public agency shall confirm the amount and duration of the AAP benefit when the child is placed, either on a voluntary basis or as a dependent or ward of the court, in out-of-home care to treat a condition that the agency has determined to have existed before the adoptive placement.

(1) The agency shall conclude that the child would have been placed in the same out-of-home care facility if the child had not been placed for adoption if, after consultation with the adoptive parents, the agency has determined that:

(A) Out-of-home placement is necessary to meet the child's needs,

(B) The specific placement is able to meet the child's needs appropriately, and

(C) The facility's rate classification level is appropriate to the child's needs.

(2) The agency shall determine the maximum AAP benefit for which the child is eligible for out-of-home placement.

(A) If the adoptive parents are paying for the cost of the placement directly, the available AAP benefit is the state-approved foster care facility rate for which the child is eligible.

(B) If the placement cost is paid by another agency (e.g., county welfare department, probation office, regional center), the available AAP benefit shall be either the age-related, state-approved foster family home care rate or the adoptive parent's actual share of cost for support of the child, whichever is greater, but not to exceed the foster family home rate as determined under Section 35333(c).

1. The maximum share of cost is the state-approved foster family home rate, eligible SCI rate or dual agency rate, and any applicable supplemental rate the child would have received had they remained in foster care.

2. Under Title 2 California Code of Regulations Section 60020(c), the county financially responsible for making AAP payments is responsible for the provision of mental health assessments and mental health services.

(3) If the initial Adoption Assistance Program Agreement (AD 4320) for the child was signed on or after October 1, 1992, the duration of a child's placement in a group home or residential treatment facility shall be limited to an 18-month cumulative period of time for a specific episode or incident justifying that placement.

(b) If the responsible public agency approves the provision of wrap-around services, as defined in Welfare and Institutions Code Section 18251(d), in lieu of out-of-home placement, the amount of the AAP benefit shall be limited to the amount that would have been paid for the out-of-home placement.

(c) The AAP benefit for the child's placement in a group home or residential care treatment facility shall continue to be available, provided the requirements of this section

are met and the adoptive parents actively participate in a plan to return the child to the adoptive home.

(d) When the responsible public agency and the adoptive parents agree on the AAP benefit, the agency shall complete an Adoption Assistance Program Agreement (AD 4320) with the adoptive parents.

(1) The agency shall state in the agreement that the AAP benefit is intended for the child's out-of-home placement and is not to exceed 18 months.

(A) The adoptive parent(s) may request the financially-responsible public agency to pay the facility directly using the child's eligible AAP funds, or the adoptive parents may request the AAP check continue to be sent to them to pay the facility.

(2) The agency shall complete the AAP 2 instructing the county to send the adoptive parents a Notice of Action indicating that the AAP benefit is approved.

(f) The duration of an Adoption Assistance Program Agreement (AD 4320) for the child's out-of-home placement shall be 18 months before a subsequent reassessment is required.

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Sections 16118, 16119, 16120, 16120.05, 16121 and 16121.05, Welfare and Institutions Code; 42 USC 673.

HISTORY

1. New section filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 3-31-2001 order, including further amendment of subsections (a)(2)(B) and (b), transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

4. Amendment of section heading, section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35335. Content of the Adoption Assistance Agreement. [Repealed]

Note: Authority cited: Sections 10553, 10554 and 16118, Welfare Institutions Code. Reference: Section 16118, Welfare Institutions Code.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former chapter 3, see Register 88, No. 1.
2. Amendment of subsection (a)(2) filed 12-1-88 (Register 89, No. 1).
3. Editorial correction of History (Register 89, No. 9).
4. Repealer of article 3 and section filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 10-31-94 order transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).
6. Editorial correction inserting History 5 (Register 95, No. 25).

§ 35337. Content of the Adoption Assistance Program Agreement.

(a) The Adoption Assistance Program Agreement form (AD 4320) shall contain the following:

(1) The child's adoptive name and the name(s) of the adoptive parent(s).

(2) The amount and duration of financial assistance.

(A) The agreement is effective until terminated in accordance with its terms or a new amended agreement is signed.

(B) The AD 4320 shall be signed by the responsible public agency and the adopting parent(s) prior to the granting of the final decree of adoption.

(C) In adoptive placements which involve more than one agency, all agencies shall sign the initial AD 4320.

1. Subsequent amendments to the AD 4320 shall be signed by the responsible public agency and adoptive parent(s).

(3) The AAP benefit will continue unless one of the following occurs:

(A) The child has attained the age of 18 unless the child has a mental or physical handicap which warrants continuation of AAP benefits to the age of 21 years.

(B) The adoptive parents are no longer legally responsible for the support of the child.

(C) The responsible public agency determines the adoptive parents are no longer providing any type of support to the child.

(4) It is the adoptive parent's responsibility to inform the responsible public agency immediately if any of the following occurs:

- (A) Change in mailing address and/or state of residence.
 - (B) The child is no longer residing in the family home.
 - (C) The adoptive parents are no longer providing any type of support to the child.
 - (D) The adoptive parents are no longer legally responsible for the support of the child.
- (5) If a needed service is not available in the state of residence, the financially responsible county of origin remains financially responsible for the needed services.
- (A) The responsible public agency shall assist the adoptive parents by providing information and referral services offered in their state of residence.
 - (B) If the child is state-eligible and eligible for state-funded Medi-Cal benefits, the adoptive parents shall be informed that if they move or reside in another state, access to medical services is contingent on whether their state of residence extends COBRA-reciprocity for children receiving California state-funded Medi-Cal benefits.
 - (6) If the adoptive parents believe their child has a physical or mental disability that warrants the continuance of assistance beyond the age of 18, prior to their child's eighteenth birthday, the adoptive parents are to request the responsible public agency assess and evaluate their child's needs for continuation of benefits beyond the age of 18.
 - (7) If the child is a current consumer of California Regional Center (CRC) services, the maximum available AAP benefit is \$3006. CRC consumers who have received an AAP benefit prior to July 2007, which exceeds the maximum \$3006 rate, may continue to receive the higher rate until the child is no longer eligible for AAP benefits or the adoption is dissolved.
- (A) If the child is under the age of three and the CRC has determined the child to have a developmental disability as defined by the Lanterman Act, the maximum AAP benefit is \$2006.
 - (B) If the child is under the age of three and receiving services under the California Early Intervention Services Act, but not yet determined by the CRC to have a developmental disability as defined by the Lanterman Act, the maximum AAP benefit is \$898 or the foster family home rate and applicable SCI rate, whichever is greater.
1. After the adoption is finalized, it is the adoptive parents' responsibility to request the CRC to evaluate the child's eligibility for CRC services and notify the responsible public agency if the child is eligible and receiving CRC services.
- (8) A child with an initial AAP agreement signed on or after January 1, 2010, will no longer be eligible to receive an AAP age-related increase.
 - (A) A child with an initial AAP agreement signed prior to January 1, 2010 will still be eligible to receive the AAP age-related increase upon request.

(B) A child with an initial Adoption Assistance Agreement signed prior to October 1, 1992, shall be governed by Welfare and Institutions Code Section 16121.05(b).

(9) That a failure to report the changes specified in Sections 35337(a)(5)(B) through (D) may result in an overpayment which would be recovered by a direct charge or a reduction in current and future AAP benefits.

(10) That continuation of payment depends upon continued legal responsibility of the adoptive parents for the support of the child and upon continued receipt by the child of that support.

(11) That the AAP benefit will be reduced if the AAP benefit amount exceeds the foster care maintenance payment that would have been made if the child had remained in a foster family home.

(12) The agreement shall specify the rate for a child receiving wraparound services or placed in an out-of-home placement which may not exceed the maximum eligible state-approved facility rate and is limited to 18 months per episode or condition. It is the adoptive parent's choice to request the AAP benefit be directed to the facility or to them and they pay the facility directly with the AAP funds received.

(13) That the child is eligible for Medi-Cal services.

(14) That the child is eligible for services provided pursuant to Title XX of the federal Social Security Act.

(A) Title XX services are public social services as described under MPP Sections 30-000 and 31-000.

(15) The procedure for reassessment of the AD 4320.

(16) That the agreement remains effective regardless of the state in which the adoptive parents reside.

(17) Any additional services and assistance which are to be provided as part of the agreement.

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Sections 14051, 16119, 16120, 16120.05, 16121 and 16121.05, Welfare and Institutions Code; 42 USC 673, 695; and 45 CFR 1356.40.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. New article 4, amendment of section heading, repealer and new text and amendment of Note filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 10-31-94 order including amendment of subsection (a)(13) and new subsection (a)(13)(A) transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

4. Amendment of article heading, section heading and section filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

5. Amendment of article heading, section heading and section refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 3-31-2001 order, including further amendment of section, transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

7. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35339. Deferred Payment of AAP.

(a) When a child otherwise eligible for AAP does not require current benefits but which could require future benefits, the Adoption Assistance Program Agreement form (AD 4320) shall indicate that the family may request benefits at an unspecified future date.

(1) The requirements set forth in Section 35333 shall be used to determine payment amount and duration if the family requests AAP benefits.

(2) An AD 4320 shall be used to record the revised agreement.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code.
Reference: Sections 16118, 16119, 16120, 16120.05, 16121 and 16121.05, Welfare and Institutions Code; and 42 USC 673 and 675.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Amendment of subsection (a), new subsections (a)(1)-(4) and amendment of Note filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 10-31-94 order transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

4. Amendment of subsection (a) filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

5. Amendment of subsection (a) refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 3-31-2001 order transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

7. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35341. Procedures for Initiation of Payment.

(a) The responsible public agency shall provide the county responsible for payment with information necessary to allow the county to issue AAP payments and authorize the issuance of Medi-Cal cards.

(1) AAP payments shall not begin before the Adoptive Placement Agreement (AD 907) and the Adoption Assistance Program Agreement (AD 4320) are signed.

(2) When the beginning date of payment is known, the agency shall complete and send the following forms to the county:

(A) Payment Instructions for Adoption Assistance Program (AAP 2),

(B) Eligibility Certification - Adoption Assistance Program (AAP 4)

(C) Income and Property Checklist for Federal Eligibility Determination - Adoption Assistance Program (FC 10).

1. The FC 10 form is to be used only for the purposes of determining AFDC eligibility in the home of removal.

(3) The child's adoptive name shall be used on the AAP 2, AAP 4, and FC 10 and all related correspondence with the county.

(A) The AAP 2 requires the creation of a new county payment case record.

(b) Upon receipt of the AAP 2, the county shall issue payments as instructed.

(1) The initial payment shall be delivered to the adoptive parent(s) no later than 20 days after the date the county receives the Payment Instructions - Adoption Assistance Program form (AAP 2) from the agency authorizing payment.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code.
Reference: Section 16118 and 16120, Welfare and Institutions Code; and 42 USC 673.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.
2. Renumbering of article heading and amendment of section filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10-31-94 order including amendment of section transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).
4. Amendment of subsection (a)(1) filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.
5. Amendment of subsection (a)(1) refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 3-31-2001 order transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).
7. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35343. Procedures for Reassessment of the Child's Needs.

(a) A reassessment shall be completed by the responsible public agency which authorized the initial payment unless one of the following is met:

- (1) The child has attained the age of 18 or 21;
- (2) The adoptive parents are no longer legally responsible for the support of the child.
- (3) The responsible public agency determines the adoptive parents are no longer providing support to the child.

(b) The reassessment process shall include the following steps:

- (1) The county responsible for payment shall mail the adoptive parent(s) the Reassessment Information Adoption Assistance Program form (AAP 3) at least 60, and not more than 90, calendar days prior to the date the reassessment is due and shall document in the case record the date such form was mailed.

(A) The adoptive parent(s) shall return the AAP 3 to the responsible public agency which authorized the initial payment.

1. If the family does not submit a completed AAP 3 form, AAP must continue at the same rate reflected on the last AAP agreement and Payment Instructions (AAP 2) form.

(2) If the responsible public agency receives the completed AAP 3 from the adoptive parents, the agency shall complete the reassessment process as follows:

(A) If the adoptive parents select box 1 on the AAP 3 indicating they no longer wish to receive an AAP benefit for their child, the agency shall follow the procedures as specified in Section 35339 for completing a deferred payment agreement.

(B) If the adoptive parents select box 2 on the AAP 3 indicating they request the AAP benefit to continue, the agency shall pay the same rate reflected on the last AAP agreement and Payment Instructions Adoption Assistance Program (AAP 2) form.

(C) If the adoptive parents select box 3 on the AAP 3, requesting an increase in the amount of the AAP benefit, the adoptive parents shall provide written documentation of the child's needs justifying the increase. The agency may require additional information as necessary.

1. The agency shall base the reassessment of the child's needs and required level of care and supervision on the following information:

a. Information provided by the adoptive parents.

b. Information about the child based on application of the county's foster care specialized care assessment instrument.

c. Circumstances of the family.

2. The responsible public agency shall follow the procedures in Section 35333 in determining the new maximum AAP benefit amount.

3. If the agency determines that a change in the amount of payment appears appropriate, the adoptive parents' concurrence shall be obtained prior to changing the amount of payment.

a. The adoptive parents' concurrence is not required if the payment amount is changed to prevent the payment from exceeding the maximum foster care maintenance payment that would have been paid had the child remained in foster care.

4. The responsible public agency and the adoptive parents shall complete an amended AD 4320 to reflect the change in the amount of AAP benefit.

a. If the agency and the adoptive parents are unable to agree on the amount of the AAP benefit, the agency shall complete an AAP 2 instructing the county to send a Notice of Action to the adoptive parents indicating that the request for additional AAP benefits is denied and that the AAP benefit will continue at the prior rate. The agency shall specify the reason for denial as "The agency and the family cannot agree on benefits."

5. The agency shall complete and send a Payment Instructions Adoption Assistance Program (AAP 2) form to the county within five working days of completing the reassessment process.

(D) If the adoptive parents select box 4 on the AAP 3, requesting a decrease in the amount of the AAP benefit, the agency and the adoptive parents shall complete an amended AD 4320 to reflect the change in benefit amount.

1. The agency shall complete and send a Payment Instructions Adoption Assistance Program (AAP 2) form to the county within five working days of completing the reassessment process.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code. Reference: Sections 16120, 16121 and 16121.05, Welfare and Institutions Code; 45 CFR 1356.40; and 42 USC 673.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Renumbering of article heading, amendment of section heading, repealer and new text and amendment of Note filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 10-31-94 order including amendment of section transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

4. Amendment of article heading, section heading and section filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

5. Amendment of article heading, section heading and section refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

6. Certificate of Compliance as to 3-31-2001 order, including further amendment of section, transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

7. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35344. Procedures for Identification and Recovery of Overpayments.

(a) An overpayment of Adoption Assistance Program (AAP) benefits may exist in the following situations:

(1) The adoptive parent receives aid after the child becomes ineligible for assistance because:

(A) The child has attained 18 years of age, or, if the agency has determined that the child has a mental or physical condition which warrants the continuation of assistance, 21 years of age.

(B) The adoptive parent is no longer supporting the child.

(C) The adoptive parent is no longer legally responsible for the support of the child.

(2) The adoptive parent has committed fraud in his or her application for, or reassessment of, the adoption assistance benefit.

(3) The AAP payment exceeds the foster care payment which would have been paid on behalf of the child if the child had not been placed for adoption.

(b) The agency which authorized payment shall compute the overpayment amount as follows:

(1) Compute the correct AAP payment based on correct information for each month.

(2) Subtract the correct AAP payment from the amount of assistance actually provided.

(c) The agency which authorized payment shall inform the county responsible for payment of the reason for the overpayment and the computation of the overpayment amount.

(d) The county shall attempt to recover the overpayment as specified in MPP Section 45-806 and Section 45-808, which provides for recovery by grant adjustment, demand for repayment, or civil judgment.

(e) The county shall not demand overpayment collection when the overpayment was due to county error.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code.
Reference: Sections 16120, 16121 and 16121.05, Welfare and Institutions Code; 45 CFR 1356.40; 42 USC 673.

HISTORY

1. New article 7 and section filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 10-31-94 order including amendment of subsection (d) transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Amendment of subsections (a)(1)-(a)(2) filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to

OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.

4. Amendment of subsections (a)(1)-(a)(2) refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 3-31-2001 order transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).

6. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35345. When Notice of Action Is Required.

(a) The agency responsible for authorizing payment shall notify the county responsible for payment by using the Payment Instructions Adoption Assistance Program form (AAP 2) regarding any of the following events which require that the county send the adoptive parent a Notice of Action (NOA):

- (1) Denial of request for adoption assistance benefits.
- (2) Completion of a deferred payment agreement (Section II of the AD 4320).
- (3) Authorization of the initial grant.
- (4) Completion of the reassessment process.
- (5) Payment termination.
- (6) An overpayment requiring collection.
- (7) Any change in grant amount.

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code.
Reference: Section 16121.05, Welfare and Institutions Code; and 45 CFR 205.10 and 1355.30.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Renumbering of article heading and amendment of section and Note filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 10-31-94 order transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

4. Amendment of subsection (a)(4) and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35347. Statutory Provisions for AAC. [Repealed]

Note: Authority cited: Sections 10553, 10554 and 16118, Welfare and Institutions Code. Reference: Section 16121.05(d), Welfare and Institutions Code.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Renumbering of article heading and amendment of subsection (a) and Note filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

3. Certificate of Compliance as to 10-31-94 order transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

4. Repealer filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35349. Chronic Health Condition and Continuation of the AAC Grant.

(a) For purposes of this section, a chronic health condition shall include one or more of the following conditions present at placement and of such nature as to make adoptive homes unavailable to the child without financial assistance:

(1) Physical or mental disability present at birth or resulting from disease or injury.

(2) Emotional disturbance.

(3) History of either injury prior to adoptive placement, physical disease, or emotional disturbance which may manifest itself in some form of physical, mental, or emotional disability after completion of the adoption.

Note: Authority cited: Section 10553, Welfare and Institutions Code; Section 1530, Health and Safety Code; and Section 8621, Family Code. Reference: Section 16121, Welfare and Institutions Code.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.

2. Change without regulatory effect amending subsections (a)(1)-(3) and Note filed 3-27-95 pursuant to section 100, title 1, California Code of Regulations (Register 95, No. 13).

§ 35351. Maintenance of Separate Records.

(a) To maintain confidentiality of the adoption case record, the responsible public agency shall maintain copies of the following documents separate from the adoption case record:

(1) The Request for Adoption Assistance (AAP 1).

(2) The Eligibility Certification - Adoption Assistance Program (AAP 4), which verifies that the child meets the Adoption Assistance Program eligibility criteria specified in Section 35326.

(3) The following documents relating to the determination of Federal eligibility:

(A) Federal Eligibility Certification for Adoption Assistance Program (FC 8).

(B) Income and Property Checklist for Federal Eligibility Determination - Adoption Assistance Program (FC 10).

(4) Documentation supporting the determination of the amount and duration of payment made pursuant to Section 35333.

(5) The initial Adoption Assistance Program Agreement (AD 4320).

(6) Completed reassessment documents, including:

(A) Reassessment Information - Adoption Assistance Program (AAP 3).

(B) The Adoption Assistance Program Agreement (AD 4320) used as an amendment to the initial agreement.

(7) Payment Instructions - Adoption Assistance Program (AAP 2).

(8) All correspondence from the county, including notices of action.

(9) State hearing decisions.

(10) All AAP related correspondence from the adoptive parent, including supporting documentation submitted to the agency by the parent.

(11) Any other correspondence relating to the determination of AAP eligibility or grant amount.

Note: Authority cited: Sections 10553 and 16118, Welfare and Institutions Code.
Reference: Sections 16118, 16120 and 16120.05, Welfare and Institutions Code; and 42 USC 671 and 673.

HISTORY

1. New section filed 9-1-87; operative 10-1-87. Ed. Note: The printing of this regulation was delayed due to necessary reformatting (Register 88, No. 50). For history of former Chapter 3, see Register 88, No. 1.
2. Renumbering of article heading and amendment of section and Note filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10-31-94 order including repealer of subsection (a)(3)(C) and subsection relettering transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).
4. Amendment of subsections (a)(5)-(a)(6)(B) filed 11-30-2000 as an emergency; operative 12-1-2000 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 3-30-2001 or emergency language will be repealed by operation of law on the following day.
5. Amendment of subsections (a)(5)-(a)(6)(B) refiled 3-30-2001 as an emergency; operative 3-31-2001 (Register 2001, No. 13). A Certificate of Compliance must be transmitted to OAL by 7-30-2001 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 3-31-2001 order transmitted to OAL 7-27-2001 and filed 9-6-2001 (Register 2001, No. 36).
7. Amendment of subsection (a), repealer of subsection (a)(3)(B), subsection relettering and amendment of Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35352. Notification Requirements for Agencies.

(a) The agency shall inform all applicants that:

- (1) Reimbursement for nonrecurring adoption expenses is available to adoptive parents who adopt a child who meets the three part special needs determination and citizenship requirements set forth in Section 35326.
- (2) Agreements entered into pursuant to this section shall meet the provisions of Section 35352.1(a)(7).
- (3) Agreements must be signed at the time of or prior to the final decree of adoption.
- (4) Claims for reimbursement must be filed with the agency responsible for payment of AAP benefits within two years of the date of the final decree of adoption.

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Sections 16119 and 16120.1, Welfare and Institutions Code; and 45 CFR1356.40 and 1356.41(e); 42 USC 673.

HISTORY

1. New article 11 and renumbering and amendment of former section 35332 to new section 35352 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 10-31-94 order including amendment of subsection (a)(1) transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Amendment of subsection (a)(1) and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35352.1. Eligibility for Reimbursement.

(a) In order for a claim to be eligible for reimbursement, the responsible public agency shall:

(1) Record in the case file that the adoption took place in compliance with applicable state and local laws.

(2) Record in the case file that the child for whose adoptive costs the parents are claiming reimbursement meets the three part special needs determination and citizenship requirements.

(3) Include verification in the case file that the expenses claimed were actual expenditures. "Verification" includes, but is not limited to, copies of the following:

(A) Cancelled checks;

(B) Signed and dated receipts.

(4) Record in the case file that the expenses claimed meet the definition of "nonrecurring adoption expenses" as defined in section 35000(n).

(5) Record in the case file that the adoptive parents have not received reimbursement for the claimed expenses from other sources. "Other sources" include, but are not limited to, the following:

(A) Reimbursement from employers;

(B) Income tax deductions.

(6) Ensure that all adoptive parents sign the Adoption Assistance Program Nonrecurring Adoption Expenses Agreement (AAP 8) with the agency prior to finalization of the adoption. The completed and signed AAP 8 shall be filed in the child's AAP file. The content of all such agreements shall meet the requirements as follows:

(A) The agreement must indicate the nature and amount of the nonrecurring expenses to be paid.

(B) The agreement may be a separate document or part of an agreement for either state or federal adoption assistance payments or services.

(7) Limit the maximum reimbursement for nonrecurring adoption expenses to \$400.00 per placement.

(A) Reimbursement for the adoptions costs incurred for the adoption of siblings shall be paid as follows:

1. Siblings placed for adoption either separately or as a unit are treated as individual placements with separate reimbursement for nonrecurring expenses up to the maximum amount allowable for each child.

(8) Record in the case file that reimbursement for nonrecurring adoption expenses in interstate placements shall conform to the following:

(A) When the adoption of the child involves interstate placement, the State that enters into an Adoption Assistance Agreement under section 473(a)(1)(B)(ii) of the Social Security Act or under a state subsidy program will be responsible for paying the nonrecurring adoption expenses of the child. In cases where there is interstate placement but no agreement for other Federal or State adoption assistance, the State in which the Final Adoption Decree is issued will be responsible for reimbursement of nonrecurring expenses if the child meets the requirements of 473(c).

Note: Authority cited: Sections 10553, 10554 and 16118(a), Welfare and Institutions Code. Reference: Section 16120.1, Welfare and Institutions Code; and 45 CFR1356.40 and 1356.41; 42 USC 673.

HISTORY

1. Renumbering and amendment of former section 35332.1 to new section 35352.1 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 10-31-94 order including amendment of subsections (a)(2) and (a)(8) transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35352.2. Authorization for Reimbursement.

(a) Pursuant to a determination that a claim for reimbursement for nonrecurring adoption expenses meets the three part special needs determination and citizenship requirements, the responsible public agency shall authorize the appropriate county to reimburse the adoptive parents.

(1) The county responsible for reimbursement shall be the county that would otherwise provide the child's AAP payment.

(A) This reimbursement shall be separate from the child's AAP payment as stated in Welfare and Institutions Code Section 16120.1(d)

(2) Reimbursement for nonrecurring adoption expenses is contingent upon the ongoing existence of the federal program for these reimbursements as mandated by Welfare and Institutions Code Section 16120.1(c).

Note: Authority cited: Sections 10553, 10554 and 16120.1(a), Welfare and Institutions Code. Reference: Section 16120.1, Welfare and Institutions Code; and 45 CFR 1356.40 and 1356.41(g); 42 USC 673.

HISTORY

1. Renumbering and amendment of former section 35332.2 to new section 35352.2 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 10-31-94 order transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Amendment of section and Note filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).

§ 35352.3. Agency Requirements for Reimbursements. [Repealed]

Note: Authority cited: Sections 10553 and 16118(a), Welfare and Institutions Code. Reference: Section 16120.1, Welfare and Institutions Code.

HISTORY

1. Renumbering and amendment of former section 35332.3 to new section 35352.3 filed 10-31-94 as an emergency; operative 11-1-94 (Register 94, No. 44). A Certificate of Compliance must be transmitted to OAL by 3-1-95 or emergency language will be repealed by operation of law on the following day.

2. Certificate of Compliance as to 10-31-94 order including amendment of subsection (b) transmitted to OAL 2-27-95 and filed 4-10-95 (Register 95, No. 15).

3. Repealer filed 11-10-2011; operative 12-10-2011 (Register 2011, No. 45).