STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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July 26, 1999

MMCD All Plan Letter 99009

TO: Medi-Cal Managed Care Health Plans

SUBJECT: DRAFT 1999 MEDI-CAL MANAGED CARE CONTRACT AMENDMENTS

The purpose of this letter is to submit to all Medi-Cal managed care plan contractors, including commercial plans and local initiative plans, draft 1999 Medi-Cal managed care plan contract amendment language for review and comment. The enclosed draft amendment language relating to recent changes in policy, law, or regulation in six subject areas, is based on the Two-Plan Model contract boilerplate. Following is a summary of each proposed contract amendment:

1. **Concurrent participation in the Medi-Cal managed care program and the Multipurpose Senior Services Program**

   (For commercial plans and local initiatives, amends Article II, Section CC, subsection 2, Definitions; and Article VI, Scope of Work, Section 6.7.2.2, Waiver Programs.)

   The amendment of these articles reflects a change in policy regarding the concurrent participation in the Medi-Cal managed care program and the Multipurpose Senior Services Program (MSSP). MSSP provides comprehensive case management and coordination of medical, social, and other services needed to support frail elderly persons in their homes and avoid placement in a facility. MSSP services do not duplicate the type of case management provided by physicians acting in the capacity of providers of primary care. MSSP clients are already assigned aid codes that would allow their participation in managed care, except for their election to enroll with MSSP. The Health Care Financing Administration has indicated that they foresee no objection to voluntary enrollment by MSSP clients. The draft amendment consists of a simple deletion and the addition of the words "Syndrome" and "and" which are technical corrections.

To provide additional clarification and guidance regarding implementation of this policy change, the Medi-Cal Managed Care Division (MMCD) will issue a separate all plan letter specific to concurrent participation in the Medi-Cal managed care program and the MSSP.

2. Definition of Contracting Officer and Contractor's Representative

(For commercial plans and local initiatives, amends Article II, General Terms and Conditions, Definitions.)

Although the Two-Plan Model contracts reference the terms "Contracting Officer" and "Contractor's Representative," they are not included in Article 2, Definitions. The draft amendment uses language in Article III, Section 3.3, Delegation of Authority, as the definition of these two terms and adds them to Article II, Definitions.

3. Minority/Women/Disabled Veteran Business Enterprises

[For commercial plans and local initiatives, amends Article III, General Terms and Conditions, Section 3.34, Minority/Women/Disabled Veteran Business Enterprises (M/W/DVBE).]

This amendment deletes language related to Minority and Women Owned Business Enterprises pursuant to the federal appellate court decision effective March 10, 1998, that declared Public Contract Code Section 10115 (the State's M/W/DVBE statute) to be unconstitutional. This decision does not effect the Disabled Veteran Business Enterprise (DVBE) Participation Program.

4. Year 2000 Compliance

(For commercial plans, amends Article III, General Terms and Conditions, by adding Section 3.36, Year 2000 Compliance; and for local initiatives, amends Article III, General Terms and Conditions, by adding Section 3.34, Year 2000 Compliance.)

MMCD All Plan Letter 99003 requires health plans, and federal Public Law 105-271, the Year 2000 Information and Readiness Disclosure Act, requires businesses to be Year 2000 compliant with respect to information technology.

5. Mandatory Child Support

(For commercial plans, amends Article III, General Terms and Conditions, adding Section 3.47, Child Support Compliance Act Acknowledgement; and for local initiatives, amends Article III, General Terms and Conditions, adding Section 3.45, Child Support Compliance Act Acknowledgement.)

Effective January 1, 1999, Chapter 899, Statutes of 1998 [Assembly Bill (AB) 1396] requires that all contracts in excess of $100,000 contain a certification made by the contractor acknowledging the importance of child support obligations and agreement to comply with all applicable laws relating to child and family support enforcement.

6. Disclosure Requirements

(For commercial plans and local initiatives, amends Article VI, Scope of Work, Section 6.9.5, Membership Services Guide.)

Three 1998 statutes include new disclosure requirements for Health Care Service Plan (HCSP) evidence of coverage and disclosure forms:

- Chapter 457, Statutes of 1998 (AB 1225), requires HCSPs to notify members of the positive benefits of organ donation and how to become an organ or tissue donor. This information must be provided annually in either the Evidence of Coverage (EOC), health plan newsletter or other direct communication to members.

- Chapter 835, Statutes of 1998 [Senate Bill (SB) 750], requires HCSPs to include a notice in the EOC if financial incentives or bonuses are used with plan providers and that members can request additional information about provider incentives from the plan, provider or provider's group.

- Chapter 68, Statutes of 1998 (AB 974), requires HCSPs to disclose if the plan uses a drug formulary, including what a formulary is, how the plan decides to include or exclude drugs from the formulary, and how often the formulary is updated. Members must be informed that they can request specific information about whether a drug is on the plan's formulary and the telephone number for requesting this information.

Comments must be submitted within 30 days of receipt of this letter. If you have questions about the enclosed draft amendments or wish to provide comments, please contact your contract manager.

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosure

Draft Amendment Language for Commercial Plan Contracts
July 1999

1. Article II, Section CC, subsection 2, Definitions, is amended to read:

CC. **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes: CalWORKs/Public Assistance Family - aid codes 30, 32, 33, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 40, 42, 54, 59, 7X; Medically Needy Family - aid code 34; Public Assistance Aged - aid codes 10, 16, 18; Medically Needy Aged - aid code 14; Public Assistance Blind - aid codes 20, 26, 28, 6A; Medically Needy Blind - aid code 24; Public Assistance Disabled - aid codes 36, 60, 66, 68, 6C, 6N, 6P, 6R; Medically Needy Disabled - aid code 64; Medically Indigent Child - aid codes 03, 04, 4C, 4K, 5K, 45, 82; Medically Indigent Adult - aid code 86; and Refugees - aid codes 01, 0A, 02, and 08, with the following exclusions:

1. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver and kidney, or combined liver and small bowel transplants.

2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, and the Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Conditions Waiver Program~~, and the Multipurpose Senior Services Waiver Program~~.

2. Article II, General Terms and Conditions, Definitions, is amended by adding Y2., Contracting Officer, and Z2., Contractor's Representative:

Y2. **Contracting Officer** means the single administrator of this Contract appointed by the Director of DHS. On behalf of DHS, the Contracting Officer will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations.

Z2. **Contractor's Representative** means the single administrator who is designated by the Contractor to make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract and federal and State laws and regulations.

NOTE: For the purpose of amending current contracts, these definitions may be added at the end of the current definitions. However, they will be inserted in alphabetical order in the boilerplate, which will mean reordering the current definitions.

3. Article III, General Terms and Conditions, Section 3.36, Minority/Women/Disabled Veteran Business Enterprises (M/W/DVBE), is amended to read:

3.36 ~~MINORITY/WOMEN/~~DISABLED VETERAN BUSINESS ENTERPRISES (~~M/W/~~DVBE)

Contractor will comply with applicable requirements of California law relating to ~~Minority/Women/~~Disabled Veterans Business Enterprises (~~M/W/~~DVBE) commencing at Section 10115 of the Public Contract Code.

4. Article III, General Terms and Conditions, is amended by adding Section 3.45, Year 2000 Compliance:

3.45 YEAR 2000 COMPLIANCE

The Contractor shall warrant and represent that the goods and services sold, leased, or licensed to the State of California, its agencies, or its political subdivisions, pursuant to this contract are "Year 2000 compliant." For purposes of this contract, goods or services are Year 2000 compliant if they continue to fully function before, at, and after the Year 2000 without interruption. If applicable, the goods and services, pursuant to this contract, will function continuously with the full ability to accurately and unambiguously process, display, compare, calculate, manipulate, and otherwise utilize date information. This warranty and representation supersedes all warranty disclaimers and limitations and all limitations on liability provided by or through the Contractor.

5. Article III, General Terms and Conditions, is amended by adding Section 3.47, Child Support Compliance Act Acknowledgement:

3.47 CHILD SUPPORT COMPLIANCE ACT ACKNOWLEDGEMENT

Effective January 1, 1999, by signing this contract that exceeds $100,000, the Contractor acknowledges that:

A. The Contractor recognizes the importance of child and family support obligations and shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings and assignment orders, as provided in Chapter 8 (commencing with section 5200 of Part 5 of Division 9 of the Family Code; and

B. The Contractor, to the best of its knowledge is fully complying with the earnings and assignment orders of all employees and providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department.

C. Questions about the New Employee Registry and reporting requirements are to be directed to the California Employment Development Department.

6. Amend Article VI, Scope of Work, Section 6.9.5, Membership Services Guide, to read:

6.9.5 Membership Services Guide

Contractor shall develop and distribute a Membership Services Guide that includes the following information:

A. The name, address and telephone number of the health plan.

B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpretive services, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services.

C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (locations of hospitals, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.

1. The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.

D. Procedures for selecting or requesting a change in Primary Care Physician, including requirements for a change in PCP; reasons for which a request may be denied; and reasons why a provider may request a change.

E. The purpose and value of scheduling an initial health assessment appointment.

F. The appropriate use of health care services in a managed care system.

G. The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers.

H. Procedure for obtaining emergency health care both within and outside Contractor's Service Area.

I. Process for referral to specialists.

J. Procedures for obtaining any non-medical transportation services offered by Contractor and through the local CHDP programs, and how to obtain such services.

K. The causes for which a Member shall lose entitlement to receive services under this Contract. (See Article III, Section 3.23.5, Disenrollment)

L. Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances.

M. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

N. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a complaint/Grievance has been submitted or if the complaint/Grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253).

O. Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

P. Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, and a description of those services, such as the following statement:

"Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get."

Q. DHS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

R. Any other information determined by DHS to be essential for the proper receipt of Covered Services.

S. Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Section 6.7.4.14, Nurse Midwife and Nurse Practitioner Services.

T. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information

with all Membership Service Guides sent to Members after the date such information is furnished to Contractor by DHS.

U. Information on how to access State resources for investigation and resolution of Member complaints, including the DHS Medi-Cal Managed Care Ombudsman toll-free telephone number (1-888-452-8609) and the DOC HMO Consumer Service toll-free telephone number (1-800-400-0815).

V. Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

W. An explanation of the expedited disenrollment process for children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

X. Information on how to obtain Minor Consent Services through Contractor's plan, and an explanation of those services.

Y. A brief explanation on how to use the Fee-For-Service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.

Z. An explanation of an American Indian Member's right to access Indian Health Service facilities and to disenroll from Contractor's plan at any time, without cause.

AA. Subsections S through Z above, except subsection T, shall be included in Contractor's Membership Services Guide by April 1, 1999, or upon the next reprinting of Contractor's Membership Services Guide, whichever is sooner.

BB. A notice regarding the positive benefits of organ donations and how a member can become an organ or tissue donor. Pursuant to California Health and Safety Code, Section 7158.2, this notice must be provided annually in the evidence of coverage, health plan newsletter or any other direct communication with Members.

CC. A statement if the plan uses provider financial bonuses or other incentives and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's group, pursuant to California Health and Safety Code, Section 1367.10.

DD. A notice that the plan uses a drug formulary, including an explanation of what a formulary is, how the plan decides which prescription drugs are included in or

excluded from the formulary, and how often the formulary is updated. Pursuant to California Health and Safety Code, Section 1363.01, this notice also must indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information.

EE. A notice if a plan uses binding arbitration to settle disputes, pursuant to the California Health and Safety Code, Sections 1363 and 1363.1, and the California Code of Civil Procedures, Section 1295.

FF. Subsections BB through EE above shall be included in the Contractor's Membership Services Guide by July 1, 1999, or upon the next reprinting of the Contractor's Membership Services Guide, whichever is sooner.

NOTE: This section has been amended not only to add new disclosure requirements, but also to require disclosure if a plan uses binding arbitration to settle disputes.

7. Amend Article VI, Scope of Work, Section 6.7.2.2, to read:

6.7.2.2 Waiver Programs

Contractor shall maintain systems for identifying and referring Members to the appropriate waiver program, including the In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, and the Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Conditions Waiver Program~~, and the Multipurpose Senior Services Waiver Program~~. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, Contractor shall initiate Disenrollment for the Member. Contractor shall provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary Covered Services to the Member.

Draft Amendment Language for Local Initiative Contracts
July 1999

1. Article II, Section CC, subsection 2, Definitions, is amended to read:

CC. **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes: CalWORKs/Public Assistance Family - aid codes 30, 32, 33, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 40, 42, 54, 59, 7X; Medically Needy Family - aid code 34; Public Assistance Aged - aid codes 10, 16, 18; Medically Needy Aged - aid code 14; Public Assistance Blind - aid codes 20, 26, 28, 6A; Medically Needy Blind - aid code 24; Public Assistance Disabled - aid codes 36, 60, 66, 68, 6C, 6N, 6P, 6R; Medically Needy Disabled - aid code 64; Medically Indigent Child - aid codes 03, 04, 4C, 4K, 5K, 45, 82; Medically Indigent Adult - aid code 86; and Refugees - aid codes 01, 0A, 02, and 08, with the following exclusions:

1. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for bone marrow, heart, heart-lung, liver, lung, combined liver and kidney, or combined liver and small bowel transplants.

2. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, and the Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Conditions Waiver Program~~, and the Multipurpose Senior Services Program~~.

2. Article II, General Terms and Conditions, Definitions, is amended by adding Y2., Contracting Officer, and Z2., Contractor's Representative:

Y2. **Contracting Officer** means the single administrator of this Contract appointed by the Director of DHS. On behalf of DHS, the Contracting Officer will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations.

Z2. **Contractor's Representative** means the single administrator who is designated by the Contractor to make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract and federal and State laws and regulations.

NOTE: For the purpose of amending current contracts, these definitions may be added at the end of the current definitions. However, they will be inserted in alphabetical order in the boilerplate, which will mean reordering the current definitions.

3. Article III, General Terms and Conditions, Section 3.34, Minority/Women/Disabled Veteran Business Enterprises (M/W/DVBE) is amended to read:

3.34 ~~MINORITY/WOMEN/~~DISABLED VETERAN BUSINESS ENTERPRISES (~~M/W/~~DVBE)

Contractor will comply with applicable requirements of California law relating to ~~Minority/Women/~~Disabled Veterans Business Enterprises (~~M/W/~~DVBE) commencing at Section 10115 of the Public Contract Code.

4. Article III, General Terms and Conditions, is amended by adding Section 3.45, Year 2000 Compliance:

3.45 YEAR 2000 COMPLIANCE

The Contractor shall warrant and represent that the goods and services sold, leased, or licensed to the State of California, its agencies, or its political subdivisions, pursuant to this contract are "Year 2000 compliant." For purposes of this contract, goods or services are Year 2000 compliant if they continue to fully function before, at, and after the Year 2000 without interruption. If applicable, the goods and services, pursuant to this contract, will function continuously with the full ability to accurately and unambiguously process, display, compare, calculate, manipulate, and otherwise utilize date information. This warranty and representation supersedes all warranty disclaimers and limitations and all limitations on liability provided by or through the Contractor.

5. Article III, General Terms and Conditions, is amended by adding Section 3.45, Child Support Compliance Act Acknowledgement:

3.45 CHILD SUPPORT COMPLIANCE ACT ACKNOWLEDGEMENT

Effective January 1, 1999, by signing this contract that exceeds $100,000, the Contractor acknowledges that:

A. The Contractor recognizes the importance of child and family support obligations and shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings and assignment orders, as provided in Chapter 8 (commencing with section 5200 of Part 5 of Division 9 of the Family Code; and

B. The Contractor, to the best of its knowledge is fully complying with the earnings and assignment orders of all employees and providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department.

C. Questions about the New Employee Registry and reporting requirements are to be directed to the California Employment Development Department.

6. Amend Article VI, Scope of Work, Section 6.9.5, Membership Services Guide, to read:

6.9.5 Membership Services Guide

Contractor shall develop and distribute a Membership Services Guide that includes the following information:

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B. A description of the full scope of Medi-Cal covered benefits and all available services including health education, interpretive services, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services.

C. Procedures for obtaining Covered Services including the address and telephone number of each Service Site (locations of hospitals, Primary Care Physicians, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities). In the case of a medical foundation or independent practice association, the address and telephone number of each Physician provider.

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J. Procedures for obtaining any non-medical transportation services offered by Contractor and through the local CHDP programs, and how to obtain such services.

K. The causes for which a Member shall lose entitlement to receive services under this Contract. (See Article III, Section 3.23.5, Disenrollment)

L. Procedures for filing a complaint/Grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving complaints/Grievances.

M. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

N. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a complaint/Grievance has been submitted or if the complaint/Grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253).

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"Family planning services are provided to Members of child bearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get."

Q. DHS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

R. Any other information determined by DHS to be essential for the proper receipt of Covered Services.

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T. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information

with all Membership Service Guides sent to Members after the date such information is furnished to Contractor by DHS.

U. Information on how to access State resources for investigation and resolution of Member complaints, including the DHS Medi-Cal Managed Care Ombudsman toll-free telephone number (1-888-452-8609) and the DOC HMO Consumer Service toll-free telephone number (1-800-400-0815).

V. Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

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Y. A brief explanation on how to use the fee-for-service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.

Z. An explanation of an American Indian Member's right to access Indian Health Service facilities and to disenroll from Contractor's plan at any time, without cause.

AA. Subsections S through Z above, except subsection T, shall be included in Contractor's Membership Services Guide by April 1, 1999, or upon the next reprinting of Contractor's Membership Services Guide, whichever is sooner.

BB. A notice regarding the positive benefits of organ donations and how a member can become an organ or tissue donor. Pursuant to California Health and Safety Code, Section 7158.2, this notice must be provided annually in the evidence of coverage, health plan newsletter or any other direct communication with Members.

CC. A statement if the plan uses provider financial bonuses or other incentives and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's group, pursuant to California Health and Safety Code, Section 1367.10.

DD. A notice that the plan uses a drug formulary, including an explanation of what a formulary is, how the plan decides which prescription drugs are included in or

excluded from the formulary, and how often the formulary is updated. Pursuant to California Health and Safety Code, Section 1363.01, this notice also must indicate that the member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information.

EE. A notice if a plan uses binding arbitration to settle disputes, pursuant to the California Health and Safety Code, Sections 1363 and 1363.1, and the California Code of Civil Procedures, Section 1295.

FF. Subsections BB through EE above shall be included in the Contractor's Membership Services Guide by July 1, 1999, or upon the next reprinting of the Contractor's Membership Services Guide, whichever is sooner.

NOTE: This section has been amended not only to add new disclosure requirements, but also to require disclosure if a plan uses binding arbitration to settle disputes.

7. Amend Article VI, Scope of Work, Section 6.7.2.2, Waiver Programs, to read:

6.7.2.2 Waiver Programs

Contractor shall maintain systems for identifying and referring Members to the appropriate waiver program, including the In-Home Medical Care Waiver Program, the Skilled Nursing Facility Waiver Program, the Model Waiver Program, and the Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Conditions Waiver Program~~, and the Multipurpose Senior Services Waiver Program~~. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, Contractor shall initiate Disenrollment for the Member. Contractor shall provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary Covered Services to the Member.