

**WAIVER DELIVERABLES REVIEWER RESPONSIBILITY LIST  
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1. Organization and Administration of Plan	1- A,B,& C can be covered by an attestation 1 D No contract for Admin.
1.A	Submit documentation of employees (current and former State employees) who may present a conflict of interest.
1.B	Submit a complete organizational chart.
1.C	Submit the following information reflecting current operation status: <ol style="list-style-type: none"> <li>1. Type of Organization (Corporation, Partnership, Sole Proprietor, Public Agency, or Other Organization)</li> <li>2. Individual Information Sheet on each natural person identified above.</li> <li>3. Contracts with Affiliated person, Principal Creditors and Providers of Administrative Services</li> <li>4. Other Controlling Persons.</li> <li>5. Contractor shall demonstrate compliance with requirements of Title 22, CCR, Sections 53874 and 53600. Identify any individual named in item b. above that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.</li> </ol>
1.D	Submit Contracts for Administrative Services.
2. Financial Information	

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2.A	Submit most recent audited annual financial reports.
2.B	Submit quarterly financial statements with the most recent quarter prior to execution of the Contract
2.C	<p>Submit the following documentation reflecting Projected Financial Viability:</p> <p>1) Projected financial statements reflecting actual and projected changes which have, or which are expected to occur between the date of the most recent financial statements and the date to begin operations in the expanded area. 2) Projected financial statements as of the close of each month during initial period of operations, and as of the close of each quarter for the following year, in the expanded area. 3) In addition, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.</p>
2.D	<p>Submit Provision for Extraordinary Losses. Include the following:</p> <p>1) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of furnishing health care services</p> <p>2) Evidence of adequate insurance coverage or self-insurance to respond to claims for other tort claims</p> <p>3) Evidence of adequate insurance coverage or self-insurance to protect Contractor against losses of facilities upon which it has the risk of loss due to fire or other causes.</p> <p>4) Evidence of fidelity bond coverage in the form of a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Commissioner</p> <p>5) Evidence of adequate workmen's compensation insurance</p>

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	coverage
2.E	Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHCS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this Proposal. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22, CCR, Sections 53863 and 53868.
2.F	Fiscal Arrangements: Submit documentation reflecting current operation status related to:  1) Maintenance of Financial Viability 2) Capitation Payments to Providers 3) Risk of Insolvency
2.G	Describe systems for ensuring that subcontractors who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a subcontract, have the administrative and financial capacity to meet its contractual obligations.
2.H	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
2.I	Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.
3. Management Information System	

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3.A	Submit a completed MCO Baseline Assessment Form.
3.B	<p>When procuring a new MIS or modifying a current system, provide a detailed implementation plan that includes:</p> <ol style="list-style-type: none"> <li>1) Outline of the tasks required;</li> <li>2) The major milestones;</li> <li>3) The responsible party for all related tasks.</li> <li>4) A full description of the acquisition of software and hardware, including the schedule for implementation;</li> <li>5) Full documentation of support for software and hardware by the manufacturer or other contracted party;</li> <li>6) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;</li> <li>7) Documentation of system changes related to pending HIPAA requirements.</li> <li>8) An Encounter data test produced from real or dummy data processed by the MIS must be submitted. Required for monthly encounter submissions.</li> <li>9) Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems: a) Financial b) Member/Eligibility c) Provider d) Encounter/Claims e) Quality Management/Utilization</li> <li>10) Submit a sample and description of the following reports generated by the MIS: a) Member roster b) Provider Listing c) Capitation payments d) Cost and Utilization e) System edits/audits f) Claims payment status/processing g) Quality Assurance h) Utilization i) Monitoring of Complaints</li> </ol>

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3.C	Submit a detailed description of how Contractor will monitor the flow of encounter data from provider level to the organization.
3.D	Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.
3.E	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
4.Quality Improvement System	N/A at this time
4.A	<p>Submit a written description of the QIS, including:</p> <ol style="list-style-type: none"> <li>1) A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity</li> <li>2) A description of the responsibility of the Governing Body in the QIS</li> <li>3) A description of the QI Committee including membership, activities, roles and responsibilities</li> <li>4) A description of how providers will be kept informed of the written QIS, its activities and outcomes</li> <li>5) A description of how Plan reports any disease or condition to public health authorities.</li> </ol>
4.B	Submit policies and procedures related to the delegation of the QIS activities.
4.C	Submit boilerplate subcontract language showing accountability of delegated QIS functions and responsibilities.
4.D	Policies and procedures to address how the Contractor will meet the requirements of:

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	1) External Accountability Set (EAS) Performance Measures 2) Quality Improvement Projects 3) Consumer Satisfaction Survey
4.E	Submit policies and procedures for performance of Primary Care Provider site reviews.
4.F	Submit a list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.
4.G	Submit the aggregate results of pre-operational, existing or in expanded areas site review to DHCS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHCS.
4.H	Submit policies and procedures for credentialing and re-credentialing.
<b>5. Utilization Management</b>	N/A at this time
5.A	Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services. Include: <ol style="list-style-type: none"> <li>1) Procedures for pre-authorization, concurrent review, and retrospective review</li> <li>2) A list of services requiring prior authorization and the utilization review criteria</li> <li>3) Procedures for the utilization review appeals process for providers and members</li> <li>4) Procedures that specify timeframes for medical authorization</li> <li>5) Procedures to detect both under- and over-utilization of health care services.</li> </ol>

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5.B	Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.
6. Provider Network	
6.A	Submit complete provider network that is adequate to provide required Covered Services for Members in Service Area.
6.B	Submit policies and procedures describing how Contractor will monitor Provider to patient ratios to ensure they are within specific standards.
6.C	Submit policies and procedures regarding physician supervision of non-physician medical practitioners.
6.D	Submit policies and procedures for providing emergency services.
6.E	Submit a complete list of specialists by type within the Contractor's network.
6.F	Submit policies and procedures for how Contractor will meet Federal requirements for access and reimbursement for in-Network and/or out-of-Network FQHC services.
6.G	Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in the Contract.
6.H	Submit a policy regarding the availability of a health plan or contracting physician 24-hours a day, 7-days a week, and procedures for communicating with emergency room personnel.

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6.I	Submit a report containing the names of all subcontracting provider groups.
6.J	Submit an analysis demonstrating the ability of the Contractor's provider network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.
6.K	Submit all boilerplate subcontracts, signature page of all subcontracts and reimbursement rates.
6.L	Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.
<b>7. Provider Relations</b>	
7.A	Submit policies and procedures for provider grievances.
7.B	Submit protocols for payment and communication with non-contracting providers.
7.C	Submit copy of provider manual.
<b>8. Provider Compensation Arrangements</b>	
8.A	Submit description of any physician incentive plans.
8.B	Submit policies and procedures for processing and payment of claims.

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8.C	Submit excerpt from the Provider Manual that describes the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.
8.D	Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities subcontracts.
8.E	Submit Policies and Procedures for the reimbursement of non-contracting Certified Nurse Midwives and Certified Nurse Practitioners.
8.F	Submit schedule of per diem rates and/or Fee-for-service rates for each of the following provider types; <ol style="list-style-type: none"> <li>1) Primary Care Providers</li> <li>2) Medical Groups and Independent Practice Associations</li> <li>3) Specialists</li> <li>4) Hospitals</li> <li>5) Pharmacies</li> </ol>
9. Access and Availability	N/A at this time
9.A	Submit policies and procedures that include standards for:

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	<ol style="list-style-type: none"> <li>1) Appointment scheduling</li> <li>2) Routine specialty referral</li> <li>3) First prenatal visit</li> <li>4) Waiting times</li> <li>5) Urgent care</li> <li>6) After-hours calls</li> <li>7) Specialty services</li> </ol>
9.B	Submit policies and procedures for the timely referral and coordination of Covered Service to which the Contractor or subcontractor has objections to perform or otherwise support.
9.C	Submit policies and procedures for standing referrals.
9.D	Submit policies and procedures regarding 24-hr./day access without prior authorization, follow-up and coordination of emergency care services.
9.E	Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.
9.F	Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

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9.G	Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.
9.H	Submit a written description of the Cultural and Linguistic Services Program. Include: 1) Policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors 2) Policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.
9.I	Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.
10. Scope of Service	N/A at this time
10.A	Submit policies and procedures for providing Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessment (IHEBA).
10.B	Submit policies and procedures, including standards, for the provision of the following services for Members under Twenty-One (21) years of age: 1) Preventive services; 2) Immunizations; 3) Blood Lead screens; 4) Screening for Chlamydia; 5) EPSDT supplemental services.
10.C Yes required	Submit policies and procedures for the provision of adult preventive services, including immunization.
10.D	Submit policies and procedures for the provision of services to pregnant Members, including: 1) Prenatal care;

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	2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines; 3) Comprehensive risk assessment tool for all pregnant Members; 4) Referral to specialists.
10.E	Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.
10.F	Provide a detailed description of health education system including policies and procedures which address:  1) Administration and oversight of the Health Education System 2) Delivery of Health Education Programs, Services and Resources 3) Evaluation and Monitoring of the Health Education System 4) Submit a timeline and work plan for the development and performance of a Group Needs Assessment that shall be completed within 12 months of the startup of operations for each county within the contractor's service area.
10.G	Provide a list and schedule of all health education programs (including classes) that are provided either directly or via subcontract by the plan.
10.H Yes required	Submit policies and procedures for the provision of:  1) Hospice care 2) Vision care – Lenses 3) Mental health services 4) Tuberculosis services
10.I	Submit standards and guidelines for the provision of Pharmaceutical services and prescribed Drugs.

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10.J	Submit a complete drug formulary.
10.K	Submit a process for review of drug formulary.
10.L	Submit policies and procedures for conducting drug utilization reviews.
11. Case Management and Coordination of Care	
11.A	Submit procedures for monitoring the coordination of care provided to Members.
11.B Yes required	Submit policies and procedures for coordinating care of Members who are receiving services from a targeted case management provider.
11.C Yes required	Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.
11.D Yes required	Submit policies and procedures for a disease management program. Include policies and procedures for identification and referral of Members eligible to participate in the disease management program.
11.E Yes required	Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the local Medi-Cal mental health plan or other community resources.
11.F Yes required	Submit policies and procedures for resolving disputes between Contractor and the local mental health plan.

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11.G	Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance abuse treatment services from both within and, if necessary, outside the Contractor's Service Area.
11.H	Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).
11.I	Submit policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program.
11.J	Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver program.
11.K	Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start program.
11.L	Submit policies and procedures for case management coordination of care of LEA services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.
11.M	Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.
11.N	Submit a description of the subcontracts or other cooperative arrangements Contractor has with the local school districts, including the subcontracts or written protocols/guidelines, if applicable.

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11.O	Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.
11.P	Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.
11.Q	Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.
11.R	Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.
11.S	Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.
11.T	Procedures to identify and refer eligible Members for WIC services.
11.U Yes required	Submit policies and procedures for assisting Members eligible for the following services:  <ol style="list-style-type: none"> <li>1) Long-term care</li> <li>2) Major organ transplants</li> <li>3) Federal Medicaid Waiver programs</li> </ol>
12. Local Health Department Coordination	Submitted
12.A	Submit executed subcontracts or documentation substantiating Contractor's efforts to enter into subcontracts with the LHD for the following public health services:

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	<ol style="list-style-type: none"> <li>1) Family planning services;</li> <li>2) STD services;</li> <li>3) HIV testing and counseling;</li> <li>4) Immunizations.</li> </ol>
12.B	<p>Submit executed subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:</p> <ol style="list-style-type: none"> <li>1) California Children Services (CCS);</li> <li>2) Maternal and Child Health;</li> <li>3) Child Health and Disability Prevention Program (CHDP);</li> <li>4) Tuberculosis Direct Observed Therapy;</li> <li>5) Women, Infants, and Children Supplemental Nutrition Program (WIC);</li> <li>6) Regional centers for services for persons with developmental disabilities.</li> </ol>
12.C	Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the local mental health plan.
<b>13. Member Services</b>	Will remain the same
13.A	Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.
13.B	Submit policies and procedures for addressing advance directives.
13.C	Submit policies and procedures for the training of Member Services staff.

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13.D	Submit policies and procedures regarding the development, content and distribution of information to Members. Address appropriate reading level and translation of materials.
13.E	Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).
13.F	Submit policies and procedures for Member selection of a primary care physician or non-physician medical practitioner.
13.G	Submit policies and procedures for Member assignment to a primary care physician.
13.H	Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within 15-days.
13.I	Submit policies and procedures demonstrating how, upon entry into the Contractor's network, the relationship between traditional and safety-net providers and their patients is not disrupted, to the maximum extent possible
13.J	Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.
<b>14. Member Grievance System</b>	Will remain the same
14.A	Submit policies and procedures relating to Contractor's Member Grievance System.
14.B	Submit policies and procedures for Contractor's oversight of the Member Grievance System for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.

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14.C	Submit format for Quarterly Grievance Log and Report.
15. Marketing	No Marketing In COHS
15.A	Submit Contractor's marketing plan, including training program and certification of marketing representatives.
15.B	Submit copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.
16. Enrollments and Disenrollments	Mandatory Enrollment
16.A	Submit policies and procedures for how Contractor will assign Members to Primary Care Physicians or a Subcontracting Health Plan.
17. Confidentiality of Medical Information	
17.A	Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.
18. Health Insurance Portability and Accountability Act (HIPAA)	
18.A	Submit policies and procedures for compliance with the Health Insurance Portability and Accountability Act of 1996.