Exhibit A
SCOPE OF WORK

1. Contractor agrees to provide to the Department of Health Care Services (DHCS) the services described herein:

   Provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of the Contract.

2. The services shall be performed at all contracting and participating facilities of the Contractor.

3. The Contract representatives during the term of this Contract will be:

Department of Health Care Services	**Contractor**
Medi-Cal Managed Care Division	**Authority dba: Health Plan Name**
Attention: Chief, Plan Management Branch	
Telephone: (916) 449-5100, (916) 449-5101	Telephone:
Fax: (916) 449-5090, (916) 449-5091	Fax:
Email:	Email:

   Direct all inquiries to:

Department of Health Care Services	**Contractor**
Medi-Cal Managed Care Division	**Authority dba: Health Plan Name**
Attention: Contracting Officer	Representative, Title
1501 Capitol Avenue, Suite 71.4001	
P.O. Box Number 997413, Mail Stop 4408	Plan
Sacramento, CA 95899-7413	Address
Telephone: (916) 449-5000	Telephone:
Fax: (916) 449-5005	Fax:
Email:	Email:

   Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

4. The following Attachments 1 through 18 are incorporated herein and made a part hereof by this reference:

   Attachment 1 - Organization and Administration of the Plan
   Attachment 2 - Financial Information
   Attachment 3 - Management Information System

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Exhibit A
SCOPE OF WORK

Attachment 4 - Quality Improvement System
Attachment 5 - Utilization Management
Attachment 6 - Provider Network
Attachment 7 - Provider Relations
Attachment 8 - Provider Compensation Arrangements
Attachment 9 - Access and Availability
Attachment 10 - Scope of Services
Attachment 11 - Case Management and Coordination of Care
Attachment 12 - Local Health Department Coordination
Attachment 13 - Member Services
Attachment 14 - Member Grievance System
Attachment 15 - Marketing
Attachment 16 - Enrollments and Disenrollments
Attachment 17 - Intentionally Left Blank
Attachment 18 – Policies, Protocols and Standards

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Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE PLAN

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHCS and maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975, Health and Safety Code Section 1340 et. seq.

2. Key Personnel (Disclosure Form)

A. Contractor shall file an annual statement with DHCS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

1) Any person or corporation also having 5% or more ownership or controlling interest in the Contractor.

2) Any director, officer, partner, trustee, or employee of the Contractor.

3) Any member of the immediate family of any person designated in 1) or 2) above.

Contractor shall comply with federal regulations 42 CFR 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106 and 42 CFR 438.610 (Prohibited Affiliations with Individuals Debarred by Federal Agencies).

3. Conflict Of Interest – Current and Former State Employees

A. This Contract shall be governed by the Conflict of Interest provisions of 22 CCR 53600.

B. Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. Contractor shall not utilize in the performance of this Contract any former State officer or employee or other appointed official in violation of the provisions of Government Code Section 87406. For purposes of this Subprovision B only, employee in the State civil service is defined to be

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Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE PLAN

any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with 28 CCR 1300.67.3 and 22 CCR 53900 et seq. Contractor shall ensure the following:

A. The organization has an accountable governing body.

B. This Contract is a high priority and that the Contractor is committed to supplying any necessary resources to assure full performance of the Contract.

C. The parent organization, if Contractor is a subsidiary, shall attest to the compliance and successful fulfillment of the terms, conditions, provisions and responsibilities set forth in this Contract. The parent organization shall also attest to providing any and all necessary resources to assure full performance of the Contract.

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the Contractor's business.

E. Written procedures for the conduct of the business of the Contractor, including the provision of heath care services, so as to provide effective controls.

5. Medical Decisions

Contractor shall ensure that medical decisions, including those by subcontractors and rendering providers, are not unduly influenced by fiscal and administrative management.

6. Medical Director

Contractor shall maintain a full time Physician as Medical Director, pursuant to 22 CCR 53913.5, whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:

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Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE PLAN

1) Rendered by qualified medical personnel.
2) Are not unduly influenced by fiscal or administrative management considerations.

B. Ensuring that the medical care provided meets the standards for acceptable medical care.

C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

D. Developing and implementing medical policy.

E. Resolve grievances related to medical quality of care.

F. Direct involvement in the implementation of Quality Improvement activities.

G. Actively participate in the functioning of the Contractor's grievance procedures as specified in Exhibit A, Attachment 14.

7. Medical Director Changes

Contractor shall report to DHCS any changes in the status of the Medical Director within ten (10) calendar days.

8. Administrative Duties/Responsibilities

Contractor shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Contract. This will include at a minimum the following:

A. Member and Enrollment reporting systems as specified in Exhibit A, Attachment 3, Management Information System, and, Exhibit A, Attachment 13, Member Services, and Exhibit A, Attachment 14, Member Grievance System.

B. A Member grievance procedure, as specified in Exhibit A, Attachment 14, Member Grievance System.

C. Data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment 3, Management Information System.

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Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE PLAN

D. Contractor shall employ a full time financial officer to maintain financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment 2. Financial Information.

E. Claims processing capabilities as described in Exhibit A, Attachment 8, Provider Compensation Arrangements.

F. Contractor shall implement and maintain a system for providing Members health education services, clinical preventive services and patient education and counseling consistent with Exhibit A, Attachment 10. Provision 7.

G. Contractor shall operate a provider Grievance procedure.

H. Contractor shall implement and maintain a Quality Improvement System consistent with Exhibit A, Attachment 4.

9. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD)or persons with chronic conditions (such as asthma, diabetes, congestive heart failure), are represented and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

10. Sensitivity Training

Contractor shall ensure that all personnel who interact with SPD beneficiaries, as well as those who may potentially interact with SPD beneficiaries, and any other staff deemed appropriate by Contractor or DHCS, shall receive sensitivity training.

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

1. Financial Viability/Standards Compliance

Contractor shall meet and maintain financial viability/standards compliance to DHCS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times shall be in compliance with the TNE requirements in accordance with 28 CCR 1300.76.

B. Administrative Costs.

Contractor's Administrative Costs shall not exceed the guidelines as established under 28 CCR 1300.78.

C. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.

D. Working capital and current ratio of one of the following:

1) Contractor shall maintain a working capital ratio of at least 1:1; or

2) Contractor shall demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding 24 months; or

3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code Section 14459. Certified Public Accountant’s audited Financial Statements shall be submitted to DHCS no later than 120 calendar days after the close of Contractor’s fiscal year. Combined Financial Statements

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

A. The independent accountant shall state in writing reasons for not preparing combined Financial Statements.

B. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified Financial Statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The Certified Public Accountant's audited Financial Statements and the DMHC required financial reporting forms shall be submitted to DHCS no later than 90 calendar days after the close of Contractor's Fiscal Year.

2) Contractor shall submit to DHCS within 30 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports. The required quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

a) Jurat.

b) Report 1A and 1B: Balance Sheet.

c) Report 2: Statement of Revenue, Expenses, and Net Worth.

d) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95. (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

e) Report 4: Enrollment and Utilization Table.

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

f) Schedule F: Unpaid Claims Analysis.

g) Appropriate footnote disclosures in accordance with GAAP.

h) Schedule H: Aging Of All Claims.

C. Contractor shall authorize its independent accountant to allow DHCS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.

D. Contractor shall submit to DHCS all financial reports relevant to Affiliates.

E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations if such reports differ in content from any financial report already submitted to DHCS.

F. Contractor shall submit to DHCS, within 30 calendar days after the close of the contractor's fiscal quarter, a Statement of Revenues, Expenses, and Net Worth including only Medi-Cal revenues and expenses using the reporting forms required by DMHC.

G. Contractor shall submit to DHCS, no later than June 1st of each contract year, projected Revenues, Expenses and Net Worth for each quarter of the following State fiscal year. The submission must include a detailed explanation of the assumptions used to develop the financial forecasts.

3. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly Financial Statements with the California Department of Managed Health Care (DMHC), Contractor and/or subcontractor shall simultaneously file an exact copy of the monthly Financial Statements with DHCS. Contractor and/or subcontractor shall submit monthly financial statements to the DHCS upon request, if deemed necessary, to monitor the Contractor and/or subcontractor's financial viability.

Contractor shall submit to DHCS no later than 30 calendar days after the close of Contractor's fiscal month, monthly financial reports in accordance with Title 22, CCR, Section 53862(c)(6). Monthly financial reports shall be prepared on the DMHC-required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat.

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

B. Report 1A and 1B: Balance Sheet

C. Report 2: Statement of Revenue, Expenses, and Net Worth.

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

E. Report 4: Enrollment and Utilization Table.

F. Schedule F: Unpaid Claims Analysis.

G. Appropriate footnote disclosures in accordance with GAAP.

H. Schedule H: Aging of All Claims.

4. Quarterly Financial Statements

Contractor shall submit to DHCS no later than 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports. Contractor's quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat.

B. Report 1A and 1B: Balance Sheet

C. Report 2: Statement of Revenue, Expenses, and Net Worth.

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

E. Report 4: Enrollment and Utilization Table.

F. Schedule F: Unpaid Claims Analysis.

G. Appropriate footnote disclosures in accordance with GAAP.

H. Schedule H: Aging of All Claims.

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

5. Annual Financial Statements

Contractor shall submit to DHCS no later than 120 calendar days after the close of Contractor's fiscal year, annual financial reports. Contractor's annual financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat.

B. Report 1A and 1B: Balance Sheet

C. Report 2: Statement of Revenue, Expenses, and Net Worth.

D. Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

E. Report 4: Enrollment and Utilization Table.

F. Schedule F: Unpaid Claims Analysis.

G. Appropriate footnote disclosures in accordance with GAAP.

H. Schedule H: Aging of All Claims.

6. Medi-Cal Line of Business Financial Statements

Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement and enrollment table on each financial reporting period required. Contractor shall prepare this income statement and enrollment table in the DMHC required financial reporting format for each specific county of operation and shall include, at a minimum, the following reports/schedules:

A. Report 2: Statement of Revenue, Expenses, and Net Worth by County.

B. Report 4: Enrollment and Utilization Table by County.

Medi-Cal line of business Financial Statements are to include expenses, revenues and enrollment only for Medi-Cal beneficiaries enrolled through direct contract with DHCS.

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

Contactor shall submit the Medi-Cal line of business financial statements within the same time frame as indicated for each required financial statement with the exception of the annual financial statement. The annual Medi-Cal line of business Financial Statements shall be submitted to DHCS no later than 120 calendar days after the close of the State fiscal year.

7. Annual Forecasts

Contractor shall submit to DHCS at least 60 days prior to the beginning of Contractor's fiscal year, an annual forecast for Contractor's next fiscal year. Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Report 2: Statement of Revenue, Expenses, and Net Worth by County. (Medi-Cal line of business)

B. Report 4: Enrollment and Utilization Table by County. (Medi-Cal line of business)

C. TNE. (All lines of business)

D. A detailed explanation of all underlying assumptions used to develop the forecast.

8. Compliance with Audit Requirements

Contractor shall cooperate with DHCS' audits. Such audits may be waived at the discretion of DHCS.

9. Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections/forecasts are requested, these statements and projections/forecasts should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28 CCR Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or subcontractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

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Exhibit A, Attachment 2
FINANCIAL INFORMATION

Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the DMHC required financial reporting format.

10. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all risk-bearing subcontracting provider groups, including but not limited to, HMOs, independent physician/provider associations (IPAs), medical groups, and Federally Qualified Health Centers and Rural Health Clinics as applicable.

11. Contractor's Obligations

Contractor is required under the terms of this Contract to provide any other financial reports/information not listed above, as deemed necessary by DHCS to properly monitor the Contractor and/or subcontractor's financial condition.

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Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM

1. MIS Capability

A. Contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS' encounter data submission. All data related to this contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services upon request. In addition to the requirements specified in 42 CFR 438.242 (b), Contractor shall have and maintain a MIS that provides, at a minimum:

1) All Medi-Cal eligibility data.

2) Information of Members enrolled in Contractor's plan.

3) Provider claims status and payment data.

4) Health care services delivery encounter data.

5) Provider network information.

6) Financial information as specified in Exhibit A, Attachment 1, regarding Administrative Duties/Responsibilities.

B. Contractor's MIS shall have processes that support the interactions between Financial, Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful. Contractor shall staff with personnel with expertise and experience necessary to support the MIS system at the commencement of the Operations Period and for the duration of this Contract.

C. Contractor shall comply with all DHCS mandated testing of the MIS to determine Contractor compliance with MIS requirements.

2. Encounter Data Submittal

Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of encounter data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements. Encounter data shall include data elements specified in DHCS' latest version of the Encounter Data Element Dictionary for

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Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM

Managed Care Plans and all existing Policy Letters related to encounter data reporting for Geographic Managed Care Plan contractors.

Contractor shall require subcontractors and non-contracting providers to provide encounter data to Contractor, which allows the Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure encounter data is complete and accurate prior to submission to DHCS. Contractor shall submit encounter data to DHCS on a monthly basis in the form and manner specified in DHCS' most recent Data Element Dictionary for Managed Care Plans, available on DHCS' website: http://www.dhcs.ca.gov/msc/psd/MIS_DSS/default.htm, and hereby incorporated by reference.

Upon written notice by DHCS that the encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is resubmitted within 15 calendar days of receipt of DHCS' notice. Upon Contractor's written request, DHCS may provide a written extension for submission of corrected encounter data.

3. MIS/Data Correspondence

Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to DHCS a Corrective Action Plan with measurable benchmarks within 30 calendar days from the date of the postmark of DHCS' written notice to Contractor. Within 30 calendar days of DHCS' receipt of Contractor's Corrective Action Plan, DHCS shall approve the Corrective Action Plan or request revisions. Within 15 calendar days after receipt of a request for revisions to the Corrective Action Plan, Contractor shall submit a revised Corrective Action Plan for DHCS approval.

4. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Contractor shall comply with Exhibit G Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and all federal and State regulations promulgated from HIPAA, as they become effective.

5. Record of Member Deaths

Contractor must submit a written report to DHCS listing deceased members to the extent Contractor has knowledge of a Member's death. The monthly report shall include the Member's name, member's Medi-Cal number, date of birth, and

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Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM

date of death until such time as a format is developed by DHCS. The monthly report is due to DHCS 30 calendar days following the end of the month.

6. Data Submission for Supplemental Maternity Payment

A. Contractor shall submit birth notification data, in the form and manner specified by DHCS, within fifteen months of the delivery date of a child born to a Member.

B. DHCS will conduct a reconciliation of the data utilizing encounter data and vital records.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in 28 CCR 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This Provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracting Physicians and contracting Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Contractor's discretion.

3. Governing Body

Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

A. Approves the overall QIS and the annual report of the QIS.

B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.

C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.

D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Medi-Cal Members, including SPD beneficiaries, and subcontractors, who are representative of the composition of the contracted provider network including but not limited to subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical subcommittee that reports to the committee.

The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

5. Provider Participation

Contractor shall ensure that contracting Physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting Providers informed of the written QIS, its activities, and outcomes.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.

2) Contractor’s oversight, monitoring, and evaluation processes and subcontractor’s agreement to such processes.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

4) Contractor's actions/remedies if subcontractor's obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.

3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within the Contractor's organization.

C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

E. The role, structure, and function of the quality improvement committee.

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

I. Description of the activities, including activities used by members that are Seniors and Persons with Disabilities and chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

8. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis. The annual report shall include:

A. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the External Accountability Set measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

B. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business,

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including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

C. An assessment of subcontractor's performance of delegated quality improvement activities.

9. External Quality Review Requirements

At least annually or as designated by DHCS, DHCS shall arrange for an external quality of care review of the Contractor by an entity qualified to conduct such reviews. Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) designated by the State in the conduct of this review.

A. External Accountability Set (EAS) Performance Measures

The EAS performance measures consist of a set of Health Plan Employer Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.

1) On an annual basis, Contractor shall submit to an on-site EAS Compliance Audit (also referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the Contractor's information and reporting systems, as well as the Contractor's methodologies for calculating performance measure rates. Contractor shall use the DHCS-selected contractor for performance of the EAS/HEDIS Compliance Audit and calculation of DHCS developed performance measures that constitute the EAS. Compliance Audits will be performed by an EQRO as contracted and paid for by the State.

2) Contractor shall calculate and report all EAS performance measures at the county level.

a) HEDIS rates are to be calculated by the Contractor and verified by the DHCS-selected EQRO. Rates for other standardized and/or DHCS-developed performance measures will be calculated by the Contractor, DHCS staff or the EQRO, as directed by DHCS.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

b) Contractor shall report audited results on the EAS performance measures to DHCS no later than June 15 of each year or such date as established by DHCS. Contractor shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.

3) Contractor shall meet or exceed the DHCS established Minimum Performance Level (MPL) for each HEDIS measure, and any other EAS performance measures required pursuant to of this Provision.

a) For each measure that does not meet the MPL set for that year, or is reported as a “Not Report” (NR) due to an audit failure, Contractor must submit a plan outlining the steps that will be taken to improve the subsequent year’s performance.

i. The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.

ii. Improvement plans are due to the DHCS within 60 calendar days of the DHCS notification that the Contractor has performed at or below the MPL for the period under review.

iii. Additional reporting may be required of the Contractor until such time as improvement is demonstrated.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

B. Under/Over-Utilization Monitoring

In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures selected by DHCS. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify Contractors of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

C. Participation in LHD Sponsored QI

Contractors in San Diego GMC shall participate in an LHD sponsored Quality Improvement committee review of quality issues, including but not limited to, Grievance trends and patterns in the Healthy San Diego GMC pilot project.

D. Quality Improvement Projects (QIPs)

1) For this Contract, Contractor is required to conduct or participate in two Quality Improvement Projects (QIPs) approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in two QIPs for each contract.

a) One QIP must be either an internal quality improvement project (IQIP) or a small group collaborative (SGC) facilitated by a health plan or DHCS. The SGC must include a minimum of four (4) DHCS health plan contractors and must use standardized measures and clinical practice guidelines. Additionally, all contracting health plans participating in a SGC must agree to the same goal, timelines for development, implementation, and measurement. Contracting health plans participating in a SGC must also agree on the nature of contracting health plan commitment of staff and other resources to the collaborative project.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

b) One QIP must be a DHCS facilitated Statewide Collaborative. If this Contract's operation start date is after the Statewide Collaborative has begun implementation, upon DHCS' approval, Contractor may substitute a SGC or an IQIP in place of the Statewide Collaborative.

2) If this Contract covers multiple counties, Contractor must include all counties in a QIP unless otherwise approved by DHCS.

3) Contractor shall comply with All Plan Letter 11-002, as well as any subsequent updates, and shall use the QIP reporting format designated therein to request approval of proposed QIPs from DHCS and to report at least annually to DHCS on the status of each QIP. The required documentation for QIP proposals and for QIP status reports shall include but is not limited to:

a) In-depth qualitative and quantitative analysis of barriers and results.
b) Evidence-based interventions and best practices, when available, and system wide intervention, when appropriate.
c) Interventions that address health disparities.
d) Measurement of performance using objective quality indicators.
e) Strategies for sustaining and spreading improvement beyond the duration of the QIP.

E. Consumer Satisfaction Survey

At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of members enrolled in Contractor's plan in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

10. Site Review

A. General Requirement

Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites, in accordance with the Site Review Policy Letter, MMCD Policy Letter 02-02 and Title 22, CCR, Section 53913. Contractor shall also conduct Facility Site Physical Accessibility reviews

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on Primary Care Provider sites and all provider sites which serve a high volume of SPD beneficiaries, in accordance with the MMCD Policy Letter 10-016 and W & I Code 14182(b)(9).

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a 5 percent sample size or a minimum of 30 sites, which ever is greater in number, shall be reviewed 6 weeks prior to plan operation. Reviews shall be completed on all remaining sites within 6 months of Plan operation. For 30 or fewer sites, reviews shall be completed on all sites 6 weeks prior to Plan operation.

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or re-credentialing.

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in MMCD Policy Letter 02-02, the Site Review Policy Letter. Primary Care Provider sites that do not correct cited deficiencies are to be terminated from Contractor network.

E. Data Submission

Contractor shall submit the site review data to DHCS by January 31 and July 31 of each year. All data elements defined by DHCS in MMCD Policy Letter 02-02 shall be included in the data submission report.

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether carried out by the Contractor, completed by other Medi-Cal Managed Care contractors or delegated to other entities.

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11. Disease Surveillance

Contractor shall implement and maintain procedures for reporting any disease or condition to public health authorities as required by State law.

12. Credentialing and Recredentialing

Contractor shall develop, and maintain written policies and procedures that include initial credentialing, re-credentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

A. Standards

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Delegated Credentialing

Contractor may delegate credentialing and re-credentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities, above.

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Exhibit A, Attachment 4
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C. Credentialing Provider Organization Certification

Contractor and their subcontractors (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

D. Disciplinary Actions

Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.

E. Medi-Cal and Medicare Provider Status

The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor's provider network.

F. Health Plan Accreditation

If Contractor has received a rating of "Excellent", "Commendable", or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of Credentialing.

Credentialing certification from other private credentialing organizations will be reviewed by DHCS on an individual basis to determine whether the Contractor shall be "deemed" to meet DHCS requirements for credentialing.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

G. Credentialing of Other Non-Physician Medical Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists and Physician Assistants have been verified in accordance with State requirements applicable to the provider category.

13. Medical Records

A. General Requirement

Contractor shall ensure that appropriate Medical Records for Members, pursuant to 28 CCR 1300.80(b)(4) and 42 USC 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each Encounter in accordance with 28 CCR 1300.67.1(c).

B. Medical Records

Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

1) Initial Health Assessment within 120 days of enrollment.

2) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

3) To ensure that medical records are protected and confidential in accordance with all federal and State laws.

4) For the release of information and obtaining consent for treatment.

5) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Record

Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

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Exhibit A, Attachment 4
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D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

1) Member identification on each page; personal/biographical data in the record.

2) Initial Health Assessment within 120 days of enrollment.

3) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

4) All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.

5) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

6) Allergies and adverse reactions are prominently noted in the record.

7) All informed consent documentation, including the human sterilization consent procedures required by 22 CCR 51305.1 through 51305.6, if applicable.

8) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

9) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

10) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

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Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

11) Health education behavioral assessment and referrals to health education services.

E. Record Maintenance

Unless a different period of time is otherwise required by law, Contractor shall maintain or cause to be maintained all records necessary to verify information and reports required by statute, regulation or contractual obligation for five years from the date of submission of the information or reports. Such records include, but are not limited to, working papers used in the preparation of reports to DHCS, financial documents, medical records, and prescription files.

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Exhibit A, Attachment 5
UTILIZATION MANAGEMENT

1. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program.

B. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

C. Allowances for a second opinion from a qualified health professional at no cost to the Member.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

E. Communications to health care practitioners of the procedures and services that require prior authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

   Contractor shall ensure that all contracted health care practitioners and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

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Exhibit A, Attachment 5
UTILIZATION MANAGEMENT

H. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G).

2. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

A. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

B. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this Provision, a qualified Physician or Contractor's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by Contractor's medical director, in collaboration with the Pharmacy and Therapeutics Committee (PTC) or its equivalent.

C. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

D. Reasons for decisions are clearly documented.

E. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13, Member Services. There shall be a well-publicized appeals procedure for both providers and Members.

F. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

G. Prior Authorization requirements shall not be applied to Emergency Services, Minor Consent Services, family planning services, preventive

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services, basic prenatal care, sexually transmitted disease services, and HIV testing.

H. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 20.

I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

3. Timeframes for Medical Authorization

A. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

B. Post-stabilization: Upon receipt of an authorization request from a provider of emergency services, Contractor shall render a decision within 30 minutes or the request is deemed approved.

C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.

D. Concurrent Review of authorization for treatment regimen already in place: Within 24 hours of the decision, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01(h)(3).

E. Retrospective review: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1).

F. Pharmaceuticals: 24 hours or one business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

G. Therapeutic Enteral Formula for Members Under 21 Years of Age: 24 hour response after receipt of request for prior authorization. Requests for Therapeutic Enteral Formula for Members Age 21 and Older shall be handled in accordance with the Timeframes for Medical Authorization set forth in Exhibit A, Attachment 5, Provision 3 (e.g., generally within five (5) working days unless criteria for expedited resolution are present).

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Exhibit A, Attachment 5
UTILIZATION MANAGEMENT

H. Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

I. Expedited authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 3 working days after receipt of the request for services. The Contractor may extend the 3 working days time period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest**.** Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

J. Hospice inpatient care: 24-hour response.

4. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.

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Exhibit A, Attachment 6
PROVIDER NETWORK

1. Network Capacity

Contractor shall maintain a provider network adequate to serve sixty percent (60%) of all Eligible Beneficiaries, including SPD beneficiaries, in the proposed county and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation, if Enrollments do not achieve seventy-five (75%) of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.

2. Network Composition

Contractor shall ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, supportive paramedical personnel, and an adequate number of accessible inpatient facilities and service sites within each service area.

3. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:

1)	Primary Care Physicians	1:2,000
2)	Total Physicians	1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

4. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with 22 CCR 51241, and that full-time equivalent Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

A.	Nurse Practitioners	1:4
B.	Physician Assistants	1:2

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Exhibit A, Attachment 6
PROVIDER NETWORK

C. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) nurse midwives or two (2) Physician assistants.

5. Emergency Services

Contractor shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24-hours-a-day, 7-days-a-week basis. This designated emergency service facility will have one or more Physicians and one Nurse on duty in the facility at all times.

6. Specialists

Contractor shall provide accessibility to medically required specialists who possess a copy of a valid diploma or certificate of satisfactory completion of a specialty residency or fellowship program accredited by the Accreditation Council of Graduate Medical Education (ACGME), through contracting or referral. Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with W & I Code section 14182(c)(2). Contractor shall provide a record/tracking mechanism for each authorized, denied, or modified referral. In addition, Contractor shall offer second opinions by specialists to any Member upon request.

7. Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access to FQHC services, including those in 42 USC 1396b(m). Contractor shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7.

8. Time and Distance Standard

Contractor shall maintain a network of Primary Care Physicians that are located within 30 minutes or 10 miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

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Exhibit A, Attachment 6
PROVIDER NETWORK

9. Plan Physician Availability

Contractor shall have a plan or contracting Physician available 24 hours per day, 7 days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically Necessary post-stabilization services, and for general communication with emergency room personnel.

10. Network Provider Availability

Contractor shall ensure that network providers offer hours of operation to Members that are no less than the hours of operation offered to other patients or to Medi-Cal FFS beneficiaries, if the provider serves only Medi-Cal beneficiaries.

11. Provider Network Report

Contractor shall submit to DHCS on a quarterly basis, in a format specified by DHCS, a report summarizing changes in the provider network.

A. The report shall be submitted at a minimum:

1) Quarterly

2) At the time of a significant change to the network affecting provider capacity and services, including:

a) Change in services or benefits;
b) Geographic service area or payments; or
c) Enrollment of a new population.

B. The report shall identify number of Primary Care Providers, provider deletions and additions and the resulting impact to:

1) Geographic access for the Members.

2) Cultural and linguistic services including provider and provider staff language capability.

3) The percentage of Traditional and Safety-Net providers.

4) The number of Members assigned to each Primary Care Physician.

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5) The percentage of Members assigned to Traditional and Safety-Net providers.

6) The network providers who are not accepting new patients.

C. Contractor shall submit the report 30 calendar days following the end of the reporting quarter.

12. Plan Subcontractors

Contractor shall submit to DHCS, a quarterly report containing the names of all direct subcontracting provider groups including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their subcontracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. The report must be sorted by subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect subcontractors. The report shall be submitted within 30 calendar days following the end of the reporting quarter.

13. Ethnic and Cultural Composition

Contractor shall ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

14. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. When doing so, Contractor shall evaluate the prospective subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(3), (4) and Title 22 CCR Section 53250, as well as those specified in this Contract. Contractor shall remain accountable for all functions and responsibilities that are delegated to subcontractors.

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(b)(2), Health and Safety Code Section 1340 et seq.; Title 28 CCR Section 1300 et seq.; Welfare and

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Exhibit A, Attachment 6
PROVIDER NETWORK

Institutions Code Section 14200 et seq. and 22 CCR 53900 et seq.; and other applicable federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract shall contain:

1) Specification of the services to be provided by the subcontractor.

2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract.

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in Subprovision C. Departmental Approval – Non-Federally Qualified HMOs, or Subprovision D, Departmental Approval – Federally Qualified HMOs.

4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.

5) Language comparable to Exhibit A, Attachment 8, Provision 13 for those subcontractors at risk for non-contracting emergency services.

6) Subcontractor's agreement to submit reports as required by Contractor.

7) Subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination or copying:

   a) By DHCS, Department of Health and Human Services (DHHS), Department of Justice (DOJ), and Department of Managed Health Care (DMHC).

   b) At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

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Exhibit A, Attachment 6
PROVIDER NETWORK

c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

d) For a term of at least five years from the close of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

e) Including all Encounter data for a period of at least five years.

8) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

9) Subcontractor's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-Subcontractor:

a) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHCS, DHHS, DOJ and DMHC.

b) Retain such books and records for a term of at least five years from the close of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

10) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 17 B Phase out Requirements, in the event of Contract termination.

11) Subcontractor's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

12) Subcontractor's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

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Exhibit A, Attachment 6
PROVIDER NETWORK

13) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.

14) Subcontractor's agreement to hold harmless both the State and Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.

15) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the subcontractor's possession, in accordance with Exhibit E, Attachment 2, Provision 26 Records Related to Recovery for Litigation.

16) Subcontractor's agreement to provide interpreter services for Members at all provider sites.

17) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.

18) Subcontractor's agreement to participate and cooperate in the Contractor's Quality Improvement System.

19) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.

20) Subcontractor's agreement to comply with all applicable requirements specified in: this Contract and subsequent amendments, federal and State laws and regulations, and MMCD Policy Letters.

21) Pursuant to Health & Safety Code Section 1261, subcontractor's agreement by any subcontracting or sub-subcontracting health facility, if subcontractor is licensed pursuant to Health & Safety Code Section 1250, to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

22) Subcontractor's agreement to provide Contractor with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under the Subcontract.

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Exhibit A, Attachment 6
PROVIDER NETWORK

C. Departmental Approval – Non-Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, a provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 calendar days of receipt.

Subcontract amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHCS, shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the Subcontract amendment, whichever is later.

D. Departmental Approval – Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provision 7, Provider Compensation Arrangements, regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontracts entered into by Contractor which is a federally qualified HMO shall be exempt from prior approval by DHCS and submitted to DHCS upon request.

E. Public Records

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS to the extent they are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the subcontractor, stockholders owning more than 5 percent of the stock issued by the subcontractor and major creditors holding more than 5 percent of the debt of the subcontractor will be attached to the Subcontract at the time the Subcontract is presented to DHCS.

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Exhibit A, Attachment 6
PROVIDER NETWORK

15. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 12 above and reimbursement requirements in Exhibit A, Attachment 8, Provision 7. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

16. Traditional and Safety-Net Providers Participation

Contractor shall ensure the participation and broad representation of Traditional and Safety-Net Providers within the Contractor's Service Area.

17. Nondiscrimination in Provider Contracts

Contractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Contractor's provider selection policies must not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Contractor to contract with providers beyond the number necessary to meet the needs of Contractor's Members; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with Contractor's responsibilities to Members.

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Exhibit A, Attachment 7
PROVIDER RELATIONS

1. Exclusivity

Contractor shall not, by use of an exclusivity provision, clause, agreement, or in any other manner, prohibit any subcontractor from providing services to Medi-Cal beneficiaries who are not Members of the Contractor's plan. This prohibition is not applicable to contracts entered into between Contractor and Knox-Keene licensed health care service plans.

2. Provider Grievances

Contractor shall have a formal procedure to accept, acknowledge, and resolve provider grievances. A provider of medical services may submit to Contractor a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to contracting, subcontracting, and non-contracting providers.

3. Non-Contracting, Non-Emergency Provider Communication

Contractor shall develop and maintain protocols for communicating and interacting, negotiating rates, and for payment of claims with non-contracting, non-emergency providers.

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Exhibit A, Attachment 7
PROVIDER RELATIONS

4. Provider Manual

Contractor shall issue a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to contracting and subcontracting health care providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements regarding the Medi-Cal Managed Care program.

Provider manuals shall include the following information about grievance, appeals, and State Fair Hearing processes, procedures and timeframes, in accordance with 42 CFR 438.414:

A. Member's right to a State Fair Hearing, how to obtain a Hearing, and representation rules at a Hearing;

B. Member's right to file grievances and appeals and their requirements and timeframes for filing;

C. Availability of assistance in filing;

D. Toll-free numbers to file oral grievances and appeals; and

E. Member's right to request continuation of benefits during an appeal or State Fair Hearing.

5. Provider Training

A. Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within 10 working days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that provider training includes, but is not limited to, information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.

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B. Contractor shall develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions. This process shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to providers.

6. Submittal of Inpatient Days Information

Upon DHCS' written request, Contractor shall report hospital inpatient days to DHCS as required by Welfare and Institutions Code Section 14105.985(b)(2) for the time period and in the form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor shall submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

7. Emergency Department Protocols

Contractor shall develop and maintain protocols for communicating and interacting with emergency departments. Protocols shall be distributed to all emergency departments in the contracted Service Area and shall include at a minimum the following:

A. Description of telephone access to triage and advice systems used by the Contractor.

B. Plan contact person responsible for coordinating services and who can be contacted 24 hours a day.

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services.

D. Procedures for emergency departments to report system and/or protocol failures and process for ensuring corrective action.

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Exhibit A, Attachment 7
PROVIDER RELATIONS

8. Prohibited Punitive Action Against the Provider

Contractor must ensure that punitive action is not taken against the provider who either requests an expedited resolution or supports a Member's appeal. Further, Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

1. Compensation

The Contractor shall not enter into any Subcontract if the compensation or other consideration which the subcontractor shall receive under the terms of the Subcontract is determined by a percentage of the Contractor's payment from the State. This Subsection shall not be construed to prohibit Subcontracts in which compensation or other consideration is determined on a capitation basis.

2. Capitation Payments

Capitation payments by a Contractor to a Primary Care Provider or clinic contracting with the Contractor on a capitation basis shall be payable effective the date of the Member's enrollment where the Member's assignment to or selection of a Primary Care Provider or clinic has been confirmed by the Contractor. However, capitation payments by a Contractor to a Primary Care Provider or clinic for a Member whose assignment to or selection of a Primary Care Provider or clinic was not confirmed by the Contractor on the date of the beneficiary's enrollment, but is later confirmed by the Contractor, shall be payable no later than 30 calendar days after the Member's enrollment.

3. Physician Incentive Plan Requirements

Contractor may implement and maintain a Physician Incentive Plan only if:

A. No specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and

B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR 417.479, 42 CFR 422.208, and 42 CFR 422.210 are met by Contractor.

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Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

4. Identification of Responsible Payor

Contractor shall provide the information that identifies the payor responsible for reimbursement of services provided to a Member enrolled in Contractor's Medi-Cal Managed Care health plan to DHCS' Fiscal Intermediary (FI) contractor. Contractor shall identify the subcontractor (if applicable) or Independent Physician Association (IPA) responsible for payment, and the Primary Care Provider name and telephone number responsible for providing care. Contractor shall provide this information in a manner prescribed by DHCS once DHCS and the FI contractor have implemented the enhancement to the California Automated Eligibility Verification and Claims Management system (CA-AEV/CMS).

5. Claims Processing

Contractor shall pay all claims submitted by contracting Providers in accordance with this section, unless the contracting Provider and Contractor have agreed in writing to an alternate payment schedule.

A. Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39. Contractor shall be subject to any Provider remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.

B. Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.

D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims as specified by 28 CCR 1300.77.1 and 1300.77.2.

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Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2, Subprovision B, Paragraph 2).

6. Prohibited Claims

A. Except in specified circumstances, Contractor and any of its Affiliates and subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract from a Medi-Cal Member or person acting on behalf of Member. Collection of claim may be made under those circumstances described in 22 CCR 53220 and 53222.

B. Contractor shall not hold Members liable for Contractor's debt if Contractor becomes insolvent. In the event Contractor becomes insolvent, Contractor shall cover the continuation of Covered Services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

7. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities

A. FQHCs Availability and Reimbursement Requirement

1) If FQHC services are not available in Contractor's provider network or the provider network of another Medi-Cal Managed Care Health Plan in the Service Area, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC, except emergency services rendered by a non-contracting FQHC or RHC shall be reimbursed as specified in Provision 13 of this Attachment.

2) If FQHC services are not available in Contractor's provider network, but are available within any other Medi-Cal Managed Care Plan's provider network in the Service Area, unless authorized by Contractor, Contractor shall not be obligated to reimburse non-contracting FQHCs for services provided to Contractor's Members, except emergency services rendered by a non-contracting FQHC or RHC, which shall be reimbursed as specified in Provision 13 of this Attachment.

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Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

B. Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Subcontracts. Contractor shall certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), FQHC and RHC Subcontract terms and conditions are the same as offered to other subcontractors providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a provider that is not a FQHC or RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHCS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and federal law and shall approve all FQHC and RHC Subcontracts consistent with the provisions of Welfare and Institutions Code Section 14087.325(h).

To the extent that Indian Health Service Facilities qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to subcontracts with Indian Health Service Facilities.

C. Indian Health Service Facilities

Contractor shall reimburse Indian Health Service Facilities for services provided to Members who are qualified to receive services from an Indian Health Service Facility as set forth in Title 42, United States Code Section, 1396u-2(h)(2); Title V of the American Recovery and Reinvestment Act of 2009, Section 5006; and, insofar as they do not conflict with federal law or regulations, the reimbursement options set forth in Title 22, California Code of Regulations (CCR), Section 55140(a).

8. Non-Contracting Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Reimbursement

If there are no CNMs or CNPs in Contractor's provider network, Contractor shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal Fee-For-Service (FFS) rates. If an appropriately licensed non-contracting facility is used, Contractor shall pay the facility fee. For hospitals, the requirements of Provision 13, Subprovision C,

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below apply. For birthing centers, the Contractor shall reimburse no less than the applicable Medi-Cal FFS rate.

9. Non-Contracting Family Planning Providers' Reimbursement

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse non-contracting family planning providers for services listed in Exhibit A, Attachment 9, Provision 8. Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

10. Sexually Transmitted Disease (STD)

Contractor shall reimburse local health departments and non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Contractor shall provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

11. HIV Testing and Counseling

Contractor shall reimburse local health departments and non-contracting family planning providers at no less than the Medi-Cal FFS rate for HIV testing and counseling. Contractor shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to the Contractor.

12. Immunizations

Contractor shall reimburse local health departments for the administration fee for immunizations given to Members. However, Contractor is not required to reimburse the local health department for an immunization provided to a Member who was already up to date. As specified in Attachment 12, Contractor shall require the local health department to provide immunization records when immunization services are billed to the Contractor. Contractor shall not be obligated to reimburse providers other than local health departments unless they enter into an agreement with the Contractor.

13. Emergency Service Providers

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Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

Contractor is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with the Contractor.

A. Emergency Services

1) Contractor may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek emergency services.

2) Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider, the Contractor, or DHCS of the Member's screening and treatment within 10 calendar days of presentation for emergency services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to provide stabilization.

B. Non-Contracting Provider Emergency Services Payment

1) Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor, or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

2) At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department

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evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

3) For all non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5 Claims Processing, above, and 42 USC Section 1396u-2(b)(2)(D), and California Welfare and Institutions code Section 14091.3.

4) Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of Welfare and Institutions Code Section 14454 and 22 CCR 53620 et. seq., except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and 22 CCR 53702.

14. Post-Stabilization Care Services and Payment

Post-stabilization care services following an emergency inpatient admission are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c).

A. Contractor is financially responsible for post-stabilization care services rendered by contracting and non-contracting providers that are either:

1) Pre-approved by Contactor or its representative; or

2) Not pre-approved by Contractor nor Contractor’s representative, but administered to maintain, improve or resolve the Member's stabilized condition if:

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Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

a) Contractor does not respond to a request for pre-approval within 30 minutes. In this situation, the necessary post stabilization care shall be deemed authorized, as specified in 28 CCR 1300.71.4; or

b) Contractor cannot be contacted; or

c) Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and Contractor's physician is not available for consultation. In this situation, Contractor must give the treating physician the opportunity to consult with Contractor's physician and the treating physician may continue with care of the Member until Contractor's physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

B. Consistent with 42 CFR 438.114(e), 422.113(c)(2), 422.214, and California Welfare and Institutions (W&I) Code Section 14091.3, Contractor is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Subprovision B, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in California Welfare and Institutions Code (W & I) Section 14166.245, which for the purposes of this Subprovision B shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Subprovision B shall constitute payment in full under this Subprovision B, and shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by Contractor pursuant to this Subprovision B.

C. Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when one of the following occurs:

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PROVIDER COMPENSATION ARRANGEMENTS

1) Contractor's physician with privileges at the treating hospital assumes responsibility for the Member's care.
2) Contractor's physician assumes responsibility for the Member's care through transfer.
3) Contractor's representative and the treating physician reach an agreement concerning the Member's care.
4) The Member is discharged.

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Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member to the Primary Care Provider. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including Physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with this Contract and applicable law.

2. Existing Patient-Physician Relationships

Contractor shall ensure that no Traditional or Safety-Net Provider, upon entry into the Contractor's network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible.

3. Access Requirements

Contractor shall establish acceptable accessibility requirements in accordance with 28 CCR 1300.67.2 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall ensure that contracting Providers offer hours of operation similar to commercial Members or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal Members. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements.

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

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ACCESS AND AVAILABILITY

B. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 2 weeks upon request.

C. Waiting Times

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision A, Appointments, above.

D. Telephone Procedures

Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

E After Hours Calls

At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.

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Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

F. Specialty Services

Contractor shall arrange for the provision of specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor providers' compliance with these standards.

A. Appropriate Clinical Timeframes

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1. Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2. Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;
5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

C. Shortening or Expanding Timeframes

Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

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D. Provider Shortage

Contractor shall be required to arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.

5. Access to Services to Which Contractor or Subcontractor Has a Moral Objection

Unless prohibited by law, Contractor shall arrange for the timely referral and coordination of Covered Services to which the Contractor or subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHCS. Contractor shall identify these services in the Member Services Guide.

6. Standing Referrals

Contractor shall provide for standing referrals to specialists in accordance with Health and Safety Code Section 1374.16, as follows:

A. Contractor shall have in place a procedure for a Member to receive a standing referral to a specialist if the primary care physician determines, in consultation with the specialist and Contractor's Medical Director or the Medical Director's designee, that a Member needs continuing care from a specialist. If a treatment plan is necessary in the course of care and is approved by Contractor, in consultation with the primary care physician, specialist, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves a current standing referral to a specialist. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the Member.

B. Contractor shall have in place a procedure for a Member with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling to receive a referral to a specialist or specialty care center that has expertise in treating

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the condition or disease for the purpose of having the specialist coordinate the Member's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center and Contractor's Medical Director or the Medical Director's designee, determines that this specialized medical care is medically necessary for the Member. If a treatment plan is deemed necessary in the course of the care and is approved by Contractor, in consultation with the primary care physician, specialist or specialty care center, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves the appropriate referral to a specialist or specialty care center.

C. Determinations for standing referrals shall be made within three (3) business days from the date the request is made by the Member or the Member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to Contractor's Medical Director or the Medical Director's designee.

D. Standing referrals do not require Contractor to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with Contractor to provide health care services to Members, unless there is no specialist within the plan network that is appropriate to provide treatment to Members, as determined by a primary care physician in consultation with Contractor's Medical Director as documented in the treatment plan.

7. Emergency Care

Contractor shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24 hours a day, 7 days a week.

A. Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1). Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS approved Emergency Department protocol (see Exhibit A, Attachment 7, Provider Relations).

B. Contractor shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care.

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ACCESS AND AVAILABILITY

C. Contractor shall ensure that a plan or contracting Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

8. Nurse Midwife and Nurse Practitioner Services

Contractor shall meet federal requirements for access and reimbursement for certified nurse midwife (CNM) services as defined in 22 CCR 51345 and certified nurse practitioner (CNP) services as defined in 22 CCR 51345.1. If Members do not have access to CNM or CNP services within Contractor's provider network, Contractor shall inform Members that they have a right to obtain out-of-plan CNM or CNP services.

9. Access to Services with Special Arrangements

A. Family Planning

Members have the right to access family planning services through any family planning provider without Prior Authorization. Contractor shall inform its Members in writing of their right to access any qualified family planning provider without Prior Authorization in its Member Services Guide (see Exhibit A, Attachment 13).

1) Informed Consent

Contractor shall ensure that Members are informed of the full array of covered contraceptive methods and that informed consent is obtained from Members for sterilization, consistent with requirements of 22 CCR 51305.1 and 51305.3.

2) Out-Of-Network Family Planning Services

Members of childbearing age may access the following services from out-of-plan family planning providers to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods.

b) Limited history and physical examination.

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c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse out-of-plan providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

d) Diagnosis and treatment of a sexually transmitted disease episode, as defined in MMCD Policy Letter 96-09 for each sexually transmitted disease, if medically indicated.

e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.

f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning provider.

g) Provision of contraceptive pills, devices, and supplies.

h) Tubal ligation.

i) Vasectomies.

j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community providers other than LHD and family planning providers, out-of-plan services are limited to one office visit per STD episode for the purposes of:

1) Diagnosis and treatment of vaginal discharge and urethral discharge.

2) Those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes

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simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

3) Evaluation and treatment of pelvic inflammatory disease.

Contractor shall provide follow-up care.

C. HIV Testing and Counseling

Members may access confidential HIV counseling and testing services through the Contractor's provider network and through the out-of-network local health department and family planning providers.

D. Minor Consent Services

Contractor shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the provider network and Members shall be informed of the availability of these services. Minors do not need parental consent to access these services. Minor Consent Services are services related to:

1) Sexual assault, including rape.

2) Drug or alcohol abuse for children 12 years of age or older.

3) Pregnancy.

4) Family planning.

5) STDs and HIV/AIDS in children 12 years of age or older.

6) Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims of incest or child abuse.

E. Immunizations

Members may access LHD for immunizations. Contractor shall, upon request, provide updated information on the status of Members' immunizations to LHDs. Subcontractors, as specified in Exhibit A,

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Exhibit A, Attachment 9
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Attachment 12, Provision 1, shall require the LHD to provide immunization records when immunization services are billed to the Contractor.

F. Indian Health Services

Contractor shall ensure Members have access to Indian Health Services pursuant to, and shall comply with all requirements of, Title 42, United States Code, Section 1396o(a), and Title V of the American Recovery and Reinvestment Act of 2009, Section 5006.

10. Changes in Availability or Location of Covered Services

Contractor shall obtain written DHCS approval prior to making any substantial change in the availability or location of services to be provided under this Contract, except in the case of natural disaster or emergency circumstance, in which case notice will be given to DHCS as soon as possible. Contractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to DHCS at least 60 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. The Contractor's proposal shall allow for timely notice to Members to allow them to change providers if desired.

11. Access for Disabled Members

Contractor's Facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

12. Civil Rights Act of 1964

Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d, 45 CFR 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin. Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members or potential members through provision of high quality interpreter and linguistic services.

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the

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delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the requirements stipulated below.

A. Written Description

Contractor shall implement and maintain a written description of its Cultural and Linguistic Services Program, which shall include at minimum the following:

1) An organizational commitment to deliver culturally and linguistically appropriate health care services.

2) Goals and objectives.

3) A timetable for implementation and accomplishment of the goals and objectives.

4) An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described.

5) Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees

Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

C. Group Needs Assessment (GNA)

Contractor shall ensure that the Health Education, Cultural and Linguistic Group Needs Assessment, as described in Exhibit A, Attachment 10, Provision 7A.3, includes identification of the cultural and linguistic needs of members including demographic profile, language preferences, need for language assistance in obtaining health care services and access to language translation services. Contractor shall demonstrate, upon

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request by the State, how the GNA findings and conclusions are utilized by the plan to provide contractually required cultural and linguistic services for members.

D. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, providers and subcontractors at key points of contact.

Contractor shall provide orientation and training on cultural competency to staff and providers serving Medi-Cal Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Medi-Cal Members. The orientation program will provide a forum for staff and providers to reflect on their own cultures and values and how they relate to delivery of services to those with differing beliefs and practices.

E. Program Implementation and Evaluation

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

14. Linguistic Services

A. Contractor shall ensure equal access to health care services for limited English proficient Members through provision of high quality interpreter and linguistic services.

B. Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries and potential members receive 24-hour oral interpreter services at all key points of contact, as defined in Subprovision E of this Provision, either through interpreters, telephone language services, or any electronic communication options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

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C. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential members:

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1) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided to all Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.

2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

3) Referrals to culturally and linguistically appropriate community service programs.

4) Telecommunications Device for the Deaf (TDD)

   TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general.

5) Telecommunications Relay Service (711)

   The 711-telephone number is the Telecommunications Information Relay Service that connects a hearing impaired person with a specially trained operator who acts as an intermediary, relaying conversations between hearing persons and persons using a TDD/TTY device.

D. Contractor shall provide translated materials to the following population groups within its Service Area as determined by DHCS:

1) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than English and that meet a numeric threshold of 3,000.

2) A population group of mandatory Medi-Cal beneficiaries residing in the Service Area who indicate their primary language as other than

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English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

E. Key points of contact include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care providers including pharmacists.

2) Non-medical care setting: Member services, orientations, and appointment scheduling.

15. Community Advisory Committee (CAC)

Contractor shall form a CAC that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers. Contractor shall ensure that the CAC is included and involved in policy decisions related to educational, operational and cultural competency issues.

16. Healthcare Surge Events

Contractor shall develop and implement policies and procedures to mitigate the effects of natural, manmade, or war-caused disasters involving broad healthcare surge events greatly impacting Contractor's health care delivery system. Contractor's policies and procedures shall ensure that Contractor will pro-actively cope with healthcare surge events resulting from such disasters or states of emergency, and shall include but are not limited to protecting enrollees, if necessary, by keeping Covered Services available to Members; keeping the revenue stream flowing to Providers in order to keep Covered Services available; transferring Members from Provider-to-Provider in the event of diminished plan capacity to keep Covered Services available; and promptly notifying DHCS of the status of the availability and locations of Covered Services, and/or Providers.

17. Out-of-Network Providers

A. If Contractor's network is unable to provide necessary medical services covered under this Contract to a particular Member, Contractor must adequately and timely cover these services out of network for the Member, for as long as the Contractor's network is unable to provide them. Out-of-network providers must coordinate with the Contractor with respect to payment. Contractor must ensure that cost to the Member is no

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greater than it would be if the services were furnished within the Contractor's network.

B. Contractor shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.

C. For newly enrolled SPD beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an out-of-network provider with whom they have an ongoing relationship if there are no quality of care issues with the provider and the provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by the Contractor identifying a link between a newly enrolled SPD beneficiary and an out-of-network provider using FFS utilization data provided by DHCS.

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1. Covered Services

A. Contractor shall provide or arrange for Members all Medically Necessary Covered Services and other services required in this Contract. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract. Contractor shall ensure that the Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under the Medi-Cal Fee-For-Service Program.

B. Contractor may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can reasonable be expected to achieve their purpose.

2. Medically Necessary Services

For purposes of this Contract, the term “Medically Necessary” will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury (22 CCR 51303(a)).

When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in 22 CCR 51340 and 51340.1.

3. Initial Health Assessment (IHA)

An IHA consists of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA) that enables a provider of primary care services to comprehensively assess the Member’s current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

A. Contractor shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with 22 CCR

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53910.5(a)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

B. Contractor shall ensure that the IHA includes the IHEBA as described in Exhibit A, Attachment 10, Provision 8, Subprovision A.

C. Contractor is responsible for assuring that arrangements are made for follow-up services and plan of care that reflect the findings and risk factors determined during the IHA.

D. Contractor shall ensure that Member's completed IHA is contained in the Member's Medical Record and available during subsequent health visits.

E. Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.

1) Contractor shall make at least three documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one telephone and one mail notification.

2) Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

4. Health Risk Stratification and Assessment for SPD Beneficiaries

Contractor shall apply a DHCS-approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and MMCD Policy Letter 11-007.

5. Services for Members under 21 Years of Age

Contractor shall ensure the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and EPSDT Supplemental Services for Members under 21 years of age, including those who have special health care needs. Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, provide comprehensive screening and

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prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically necessary services.

Contractor shall cover all medically necessary mandatory and supplemental services for Members under 21 years of age including health education services, vision, dental and hearing services, and various therapies and other long-term services and supports. In addition to ensuring coverage of EPSDT services, Contractor shall ensure an adequate level of benefits and services. Contractor shall also ensure that appropriate EPSDT services are initiated in a timely fashion, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

A. Provision of IHAs for Members under Age 21

1) For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 60 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger, whichever is less.

2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

3) Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each Member under 21 years of age at the time of enrollment is accomplished at the IHA. The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the Member under 21 years of age is up-to-date.

4) For all Members under 21 years of age, Contractor shall ensure that the IHA includes the IHEBA, as described in Exhibit A, Attachment 10, Provision 7, Suprovision A.

B. Preventive Services for Members under Age 21

1) Contractor shall provide preventive services for all Members under 21 years of age as specified by the most recent AAP guidelines and periodicity schedule. Contractor shall ensure that these preventive

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health visits include age specific assessments and services required by the CHDP program. When the AAP periodicity examination schedule occurs more frequently than the CHDP examination schedule, Contractor shall ensure that the AAP periodicity schedule is followed and that the scheduled assessment and services include all content required by the CHDP for the age level at or higher than the AAP schedule age.

2) Contractor shall ensure that preventive health visits for Members under 21 years of age include the IHEBA, as described in Exhibit A, Attachment 10, Provision 7, Subprovision A.

3) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian, or through a referral from the local CHDP program, an appointment shall be made for the Member to be examined within two weeks of the request.

4) At each non-emergency Primary Care Encounter with Members under 21 years of age, the Member (if an emancipated minor or age 18 or older) or the parent(s) or guardian of the Member shall be advised of the preventive services due and available from Contractor, if the Member has not received preventive services in accordance with CHDP preventive standards. Documentation shall be entered in the Member's Medical Record which shall indicate the receipt of preventive services in accordance with the CHDP standards or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor or age 18 or older) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

5) The Confidential Screening/Billing Report form, PM-160 INF, shall be used to report all preventive services encounters. The Contractor shall submit completed forms to DHCS and to the local children's preventive services program within 30 calendar days of the end of each month for all encounters during that month.

C. Immunizations for Members under age 21

Contractor shall ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations approved by the Centers for Disease Control and

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Prevention (CDC) and published in the Morbidity and Mortality Weekly Report (MMWR).

Contractor shall develop policies and procedures for the timely provision and administration of vaccines. Policies and procedures shall be developed within 30 calendar days of CDC's approval date of a vaccine. In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations.

If immunizations cannot be given at the time of the visit, the Member must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made.

Contractor shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member, or guardian of the Member, if appropriate, shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Additional attempts to provide the immunization at subsequent member office visit(s) must be documented.

Contractor shall provide information to all network providers regarding the Vaccine for Children (VFC) Program.

D. Blood Lead Screens

Contractor shall cover and ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, CCR, Division 1, Chapter 9, commencing with Section 37000. Contractor shall document and appropriately follow up on blood lead screening test results.

Contractor shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's Medical Record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent(s) or guardian shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

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E. Screening for Chlamydia for Members 25 years of age and younger

Contractor shall screen all sexually active females 25 years of age and younger for chlamydia in accordance with the United States Preventive Services Taskforce (USPSTF) recommendations. Follow up of positive results must be documented in the Medical Record.

Contractor shall make reasonable attempts to contact the appropriately identified Members and provide screening for chlamydia. Contractor shall document attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and screen for chlamydia and shall be considered towards meeting this requirement.

If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor or age 18 or older) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record.

6. Services for Adults (Age 21 and older)

A. Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

Contractor shall ensure that the performance of the initial comprehensive history and physical exam for adults includes, but is not limited to:

1) A comprehensive history including, but not limited to, mental and physical systems, and social and past medical history.
2) Status of currently recommended preventive services.
3) Comprehensive physical and cognitive exam sufficient to assess and diagnose acute and chronic conditions.
4) Diagnoses and plan of care including follow-up activities.

Contractor is responsible for assuring that arrangements are made for follow-up services and plan of care that reflect the findings and risk factors determined during the IHA.

Contractor shall ensure that Member's completed IHA is contained in the Member's Medical Record and available during subsequent health visits.

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For all Adults, Contractor shall ensure that the IHA includes the IHEBA, as described in Exhibit A, Attachment 10, Provision 7, Subprovision A.

B. Adult Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult Members. These standards also serve as a baseline for assessment against which care actually delivered will be measured for rates of Utilization. DHCS will utilize acceptable utilization rates for these standards and guidelines based on evaluation of experiential data from all Medi-Cal Managed Care Plans and from other sources.

1) Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by USPSTF is used as a minimum guideline to determine the provision and frequency of clinical preventive services to asymptomatic, healthy adult Members age 21 or older. As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

2) Contractor shall cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. Contractor shall ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

3) Contractor shall ensure that adult preventive services includes the IHEBA, as described in Exhibit A, Attachment 10, Provision 7, Subprovision A.

C. Adult Immunizations

Contractor is responsible for assuring that all adults are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in

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accordance with the most recent recommendations approved by CDC, if the vaccine is deemed a covered benefit by the Medi-Cal Program.

Contractor shall develop policies and procedures for the timely provision and administration of vaccines. Policies and procedures shall be developed within 30 calendar days of the CDC's approval date of a vaccine.

In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings, and or the presence of risk factors identified in the IHEBA.

If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member, if appropriate, shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record. Additional attempts to provide the immunization at subsequent member office visit(s) must be documented.

D. Screening for Chlamydia for Members age 25 and under

Contractor shall screen all sexually active females 25 years of age and younger for Chlamydia in accordance with USPSTF recommendations. Follow up of positive results must be documented in the Medical Record.

Contractor shall make reasonable attempts to contact the appropriately identified Members and provide screening for Chlamydia. Contractor shall document attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and screen for Chlamydia and shall be considered towards meeting this requirement.

If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member or guardian of the Member, if appropriate, shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record.

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7. Perinatal Services

A. Prenatal Care

Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

B. Risk Assessment

Contractor shall implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per 22 CCR 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, health education, psychosocial, and risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the Medical Record.

C. Referral to Specialists

Contractor shall ensure that pregnant Members at high risk of a poor pregnancy outcome are provided timely referral to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available and accessible to the Member within the provider network to provide necessary high-risk pregnancy services.

8. Services for All Members

A. Health Education

1) Contractor shall implement and maintain a health education system that provides the organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education to assist Members improve their health and manage illness.

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2) Contractor shall ensure administrative oversight, direction, management, and supervision of the health education system by a qualified, full-time health education director or manager possessing a master of public health degree (MPH) with an emphasis in health education from a school and program of public health accredited by the Council on Education for Public Health. Contractor shall maintain the organization and staffing to ensure successful implementation and maintenance of an effective health education system. Health education program activities must be coordinated and integrated with the Contractor's overall health care and quality improvement plan.

3) Contractor shall conduct a Health Education, Cultural and Linguistic Group Needs Assessment (GNA) to identify the health education, cultural and linguistic needs of Members, and utilize the findings for continuous development and improvement of contractually required health education programs and services. Contractor shall use multiple, reliable data sources, methodologies, techniques, and tools to conduct the GNA. A GNA shall be conducted for each county in the Service Area and shall be completed within 12 months from the commencement of operations in each county and at least every 5 years thereafter. For contracts existing at the time this Provision becomes effective, the next GNA will be required at a time within this 5 year period, to be determined by DHCS.

a) Contractor shall submit a GNA Summary Report to DHCS at the completion of each GNA. The Summary Report shall include: objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references. Findings and conclusions must include the following information for Members: demographic profile; related health risks, problems and conditions; related knowledge, attitudes and practices including cultural beliefs and practices; perceived health education needs including learning needs; preferred methods of learning and literacy level; and culturally competent community resources.

b) Contractor shall update the GNA Summary Report annually and shall maintain, and have available for DHCS review, each Annual GNA Summary Report Update. The GNA Annual Report Update shall include: objectives, methodology, data sources, survey instruments, findings and conclusions; program and policy implications, and

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references. Findings and conclusions must include the following updated information with an analysis of changes and trends:

i. Demographic profile of the Contractor's Medi-Cal membership;
ii. Health risks, problems and conditions, and health disparities among Members;
iii. Health education needs, cultural and linguistic needs; and
iv. Culturally competent community resources.

The program and policy implications section must describe current health education services and programs accompanied by a description and rationale of how and why they are being modified or expanded to address updated GNA findings and conclusions.

4) Contractor shall ensure, and maintain documentation to demonstrate, that the findings described in the GNA Summary Report and the Annual GNA Summary Report Updates, as well as other relevant information, are used to establish health education program priorities and appropriate levels and types of intervention for specific health issues and target populations. Contractor shall review the health education system annually to ensure appropriate allocation of health education resources based upon needs assessment findings, program evaluation results, and other program data.

5) Contractor shall ensure the organized delivery of health education programs and services, at no charge for Members, using a variety of educational strategies, methods and materials that are appropriate for the Member population and effective in achieving behavioral change for improved health. Contractor shall ensure that all health education information and materials are provided to Members at no higher than a 6th grade reading level, unless otherwise approved by DHCS, and are provided in a manner and form that are easily understood and culturally and linguistically appropriate for the intended audience.

6) Contractor shall provide health education programs and services directly and/or through subcontractors that have expertise in delivery of health education programs and services. Contractor

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shall conduct targeted outreach to promote optimal program use and participation by Members.

7) Contractors shall maintain a health education system that provides educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by providers and also upon the Member's request.

   a) Effective use of Managed Health Care Services: Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care.

   b) Risk-Reduction and Healthy Lifestyles: Educational interventions designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting.

   c) Self-Care and Management of Health Conditions: Educational interventions designed to assist Members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension.

8) Contractor shall ensure that Members receive health education services as part of preventive and primary health care visits. Contractor shall ensure that health risk behaviors, health practices and health education needs related to health conditions are identified, and that educational interventions, including counseling and referral for health education services, are conducted and documented in the Member's Medical Record. Contractor shall ensure that medical providers use the IHEBA tool and other relevant clinical evidence as part of the basis for identifying Members' health education needs and conducting educational intervention. Contractor shall provide resource information,

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educational materials and other program resources to assist providers to provide effective health education services for Members.

9) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the initial health assessment and that all existing Members complete the IHEBA at their next non-acute care visit, but no later than their next scheduled health screening exam.

Contractor shall ensure that:

a) the DHCS Form 7098 and bilingual translations, or alternative tools approved by DHCS, are used by Primary Care Providers (PCP) to satisfy the IHEBA requirement;
b) the IHEBA is administered and reviewed by the PCP during an office visit;
c) the IHEBA is reviewed at least annually by the PCP with Members who present for a scheduled visit;
d) the IHEBA is re-administered by the PCP at the appropriate age-intervals utilized by the Staying Healthy Assessment (0-3 years, 4-8 years, 9-11 years, 12-17 years, and 18 years and older). This should occur at the patient's first scheduled health screening exam upon changing into the next age group.
e) the IHEBA includes documentation, at initial and subsequent visits, of health education interventions, risk factors addressed, intervention codes, date and primary care provider's signature or initials.
f) the completed IHEBA tool is included along with the medical history and problem list as a permanent part of the Member's Medical Record.
g) assistance is provided to Members in completing the assessment tool, if needed.
h) interventions are conducted and arrangements are made for follow-up services to address the needs identified by the IHEBA.

Contractor is responsible to assist Primary Care Providers in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate and visually and hearing impaired Members.

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10) Contractor shall ensure education and training of contracting medical providers, practitioners, and allied health care personnel to support delivery of effective health education services for Members. Education and training must cover at least the following topics:

    a) IHEBA;
    b) Techniques to enhance effectiveness of provider/patient interaction;
    c) Plan-specific and community resource and referral information;
    d) Health education requirement standards, guidelines and monitoring; and,
    e) Group Needs Assessment findings.

    Provider training on GNA findings shall include information about the identified cultural groups in the Contractor's Service Area, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; traditional home remedies that may impact patient care, and language and literacy needs.

11) Contractor shall adopt and maintain appropriate health education program standards/guidelines and policies/procedures, and conduct appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation, to ensure access, availability and effectiveness in achieving health education program goals and objectives. Contractor shall maintain documentation that demonstrates effective implementation of all DHCS health education requirements under this Contract.

12) Contractor shall monitor the performance of Subcontractors that deliver health education programs and services to Members, and implement strategies to improve performance and effectiveness.

13) Contractor shall monitor access and availability of health education programs and services, and implement strategies to remove barriers to Member participation including, but not limited to, distance barriers (program location), availability barriers (frequency and timing of program offerings), and cultural and linguistic barriers.

14) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 11.

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B. The Health Information Form (HIF)/Member Evaluation Tool (MET)

Contractor shall use data from the HIF and submitted through the MET to help identify newly enrolled Members who may need expedited services.

C. Hospice Care

1) Contractor shall cover and ensure the provision of hospice care services as defined in Sections 1905(o)(1) of the Social Security Act. Contractor shall ensure that Members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. Services shall be limited to individuals who have been certified as terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified. However, for a member under age 21, a voluntary election of hospice care shall not constitute a waiver of any rights of that member to be provided with, or to have payment made for covered services that are related to the treatment of that member's condition for which a diagnosis of terminal illness has been made.

For Members who have elected hospice care, Contractor shall arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible. Contractor shall cover the cost of all hospice care provided. Contractor is also responsible for all medical care not related to the terminal condition.

2) Admission to a nursing facility of a Member who has elected covered hospice services as described in 22 CCR 51349, does not affect the Member's eligibility for enrollment under this Contract. Hospice services are Covered Services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing facility.

D. Vision Care

Contractor shall cover and ensure the provision of Vision Care services pursuant to W & I Code Section 14131.10.

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Exhibit A, Attachment 10
SCOPE OF SERVICES

E. Mental Health Services

1) Contractor shall cover outpatient mental health services that are within the scope of practice of Primary Care Physicians. Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Physicians. In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers, except those specifically excluded in this Contract as stipulated below.

2) Contractor shall cover all Medically Necessary Covered Services for the Member, including the following services:

a) Emergency room professional services, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other Specialty Mental Health Providers.

b) Facility charges for emergency room visits which do not result in a psychiatric admission.

c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.

d) Emergency medical transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in 22 CCR 51323.

e) All non-emergency medical transportation services, as provided for in 22 CCR 51323, required by Members to access Medi-Cal covered mental health services, subject to a written prescription by a Medi-Cal Specialty Mental Health Provider, except when the transportation is required to transfer the Member from one facility to another, for the purpose of reducing the local Medi-Cal mental health program's cost of providing services.

f) Medically Necessary Covered Services after Contractor has been notified by a Specialty Mental Health Provider that a Member has been admitted to a psychiatric inpatient

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hospital, including the initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services. However, notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital admission by Members.

g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract.

i. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of-plan psychiatrists for Members.

ii. Contractor may require that covered prescriptions written by out-of-plan psychiatrists be filled by pharmacies in Contractor's provider network.

iii. Reimbursement to pharmacies for those psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual, Geographic Managed Care, Capitated/ Noncapitated Drugs section, which lists excluded psychiatric drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this Provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

h) Subparagraphs c), e), and f) above shall not be construed to preclude Contractor from: 1) requiring that Covered Services be provided through Contractor's provider network, to the extent possible, or 2) applying Utilization Review controls for these services, including Prior Authorization, consistent with Contractor's obligation to provide Covered Services under this Contract.

3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services (services outside the scope of practice of Primary Care Physicians) are referred to and are provided mental health

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services by an appropriate Medi-Cal FFS mental health provider or to the local mental health plan for Specialty Mental Health Services in accordance with Exhibit A, Attachment 11, Provision 5.

4) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service provider(s). Contractor shall enter into a Memorandum of Understanding with the county mental health plan in accordance with Exhibit A, Attachment 12, Provision 3, Local Mental Health Plan Coordination.

F. Tuberculosis (TB)

TB screening, diagnosis, treatment and follow-up are covered under the Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.

Contractor shall coordinate with Local Health Department in the provision of direct observed therapy as required in Exhibit A, Attachment 11, Provision 15, Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB), and Attachment 12, Local Health Department Coordination.

G. Pharmaceutical Services and provision of Prescribed Drugs

1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations including, but not limited to the California State Board of Pharmacy Laws and Regulations, 22 CCR 53214 and 53854 and 16 CCR Sections 1707.1, 1707.2, and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and provider manuals of the Contractor.

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours.

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Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following:

a) Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency room medication dispensing requirements are met, including, if applicable, specific language in network hospital subcontracts. Written policies and procedures must describe how Contractor and/or Contractor's network hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of receipt of medications for each and every ER visit made by Members to an emergency room which does not result in hospitalization;

b) Providing the Member, in all cases, access to at least a 72-hour supply of Medically Necessary drugs. This requirement can be met by providing a 72-hour supply of the drug to the Member, or provision of an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. Contractor's policies and procedures can describe other methods for ensuring compliance with the 72-hour requirement.

c) Having a mechanism in place for informing Members of this requirement and of their right to submit a grievance if they do not receive Medically Necessary medications in emergency situations;

d) Having a procedure for investigating and resolving Member complaints/grievances related to the failure of Contractor to provide Medically Necessary medications in emergency situations.

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e) Having policies and procedures and complaint and grievance logs available for inspection during any state audit or monitoring visit, upon request.

2) Contractor shall submit to DHCS a complete formulary. The Contractor may use the formulary as published unless DHCS notifies the Contractor of changes that must be made. A report of changes to the formulary shall be submitted to DHCS upon request and on an annual basis. Contractor's formulary shall be comparable to the Medi-Cal FFS List of Contract Drugs, except for drugs carved out of this Contract. Comparable means that the Contractor's formulary must contain drugs which represent each mechanism of action sub-class within all major therapeutic categories of prescription drugs included in the Medi-Cal FFS List of Contract Drugs. All drugs listed on the Medi-Cal FFS list need not be included in Contractor's formulary.

3) The Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated, no less than quarterly, by Contractor's Pharmacy and Therapeutics (P&T) Committee, which will include the Contractor's Pharmacist as a voting member on the Committee. This review and update must consider all drugs approved by the FDA and/or added to Medi-Cal FFS List of contract Drugs. Deletions to the formulary must be documented and justified.

4) Contractor's process should also ensure that drug utilization reviews are appropriately conducted and that pharmacy service and drug utilization encounter data are provided to DHCS on a monthly basis.

5) Reimbursement to pharmacies for those drugs for the treatment of HIV/AIDS that are listed in the Medi-Cal Provider Manual, Geographic Managed Care, Capitated/Noncapitated Drugs section, which lists excluded HIV/AIDS drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider. To qualify for reimbursement under this Provision, a pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program.

H. Other Standards

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For health service delivery areas where DHCS has not specified standards or practice guidelines, the Contractor may adopt nationally recognized standards, best practices guidelines and/or recommendations from appropriate professional organizations of proven methods that are time-tested, research supported and accepted by peer professionals as reasonable practice.

9. Investigational Services

Contractor shall provide investigational services as defined in 22 CCR 51056.1(b) when a service is determined to be investigational pursuant to Section 51056.1(c), and that all requirements in Section 51303(h) are clearly documented.

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Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

1. Comprehensive Case Management Including Coordination of Care Services

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the Member.

A. Basic Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include:

1) Initial Health Assessment (IHA)

2) Initial Health Education Behavioral Assessment (IHEBA)

3) Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs

4) Direct communication between the provider and Member/family

5) Member and family education, including healthy lifestyle changes when warranted

6) Coordination of carved out and linked services, and referral to appropriate community resources and other agencies.

B. Complex Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum:

1) Basic Case Management Services;

2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team;

3) Intense coordination of resources to ensure member regains optimal health or improved functionality;

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Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.

C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/ Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.

D. Person-Centered Planning for SPD Beneficiaries

1) Upon the enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs.

2) Person-Centered Planning shall include identifying each SPD beneficiary's preferences and choices regarding treatments and services, and abilities.

3) Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

2. Discharge Planning and Care Coordination

Contractor shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.

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Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

B. Documentation of pre-discharge factors, including an understanding of the medical condition by SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.

D. Summary of the nature and outcome of SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

3. Targeted Case Management Services (TCM)

Contractor is responsible for determining whether a member requires TCM services, and must refer members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

If a Member is receiving TCM services as specified in 22 CCR 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM provider that are Covered Services under the Contract.

4. Disease Management Services

Contractor is responsible for initiating and maintaining disease management services for Members who are at risk of adverse health outcomes and/or higher utilization of services. Contractor shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate.

5. Out-of-Plan Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to

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ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6 through 18 below.

6. Specialty Mental Health

A. Specialty Mental Health Services

1) All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.

2) Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:

a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the local Medi-Cal mental health plan, as defined in MMCD Mental Health Policy Letter 00-01 Revised, the Member shall be referred to the local mental health plan.

b) For those Members whose psychiatric diagnosis is not covered by the local Medi-Cal mental health plan, the Member shall be referred to an appropriate Medi-Cal FFS mental health provider. Contractor shall consult with the local Medi-Cal mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available mental health services.

3) Disputes between Contractor and the local Medi-Cal mental health plan regarding this section shall be resolved pursuant to Title 9 CCR 1850.505.

B. Local Mental Health Plan Coordination

Contractor shall execute a Memorandum of Understanding (MOU) with the local mental health plan as stipulated in Exhibit A, Attachment 12 Local Health Department Coordination, Provision 3, for the coordination of Specialty Mental Health Services to Members.

7. Alcohol and Substance Abuse Treatment Services

Alcohol and substance abuse treatment services available under the Drug Medi-Cal program as defined in 22 CCR 51341.1, and outpatient heroin detoxification services defined in 22 CCR 51328 are excluded from this Contract. These

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excluded services include most drugs used for the treatment of alcohol and substance abuse covered by State of California, Department of Alcohol and Drug Programs (ADP), Medi-Cal Substance Abuse Services, as well as specific drugs listed in the Medi-Cal Provider Manual, MCP: Geographic Managed Care, Capitated/Noncapitated Drugs section, which lists the specific alcohol and substance abuse drugs not currently covered by ADP, but reimbursed through the Medi-Cal FFS program. To the extent a pharmacy is seeking Medi-Cal FFS reimbursement for drugs for the treatment of Alcohol and Substance Abuse that are listed in the Medi-Cal Provider Manual, MCP: Geographic Managed Care, Capitated/Noncapitated Drugs section, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-plan pharmacy provider, the pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program to qualify for Medi-Cal FFS reimbursement.

Contractor shall identify individuals requiring alcohol and or substance abuse treatment services and arrange for their referral to the ADP, including outpatient heroin detoxification providers, for appropriate services. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available in the ADP within the Contractor's Service Area, the Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment and coordinate services between the primary care providers and the treatment programs.

8. Services for Children who are under 21 years of age with Special Health Care Needs

Contractor shall implement and maintain services for Children with Special Health Care Needs (CSHCN) that include but are not limited to, the following:

A. Standardized procedures that include health care provider training for the identification of CSHCN, at enrollment and on a periodic basis thereafter.

B. Methods for ensuring and monitoring timely access to pediatric specialists, sub-specialists, ancillary therapists, community resources, and specialized equipment and supplies; these may include assignment to a specialist as Primary Care Physician, standing referrals, or other methods as defined by Contractor.

C. Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all Medically Necessary follow-up services are documented in the medical record, including needed referrals.

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Exhibit A, Attachment 11
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D. Case management or care coordination of services for CSHCN, including coordination with other entities that provide services for CSHCN (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

E. Methods for monitoring and improving the quality and appropriateness of care for CSHCN.

9. California Childrens Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:

1) Ensure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS eligible medical condition.

2) Assure that contracting Providers understand that CCS reimburses only CCS paneled providers and CCS-approved hospitals within Contractor's network; and only from the date of referral.

3) Enable initial referrals of Member's with CCS eligible conditions to be made to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

4) Ensure that Contractor continues to provide all Medically Necessary Covered Services for the Member's CCS eligible condition until CCS eligibility is confirmed.

5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are unrelated to the CCS eligible

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condition and shall monitor and ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program.

6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members.

C. The CCS program authorizes Medi-Cal payments to Contractor network physicians who currently are members of the CCS panel and to other providers who provided CCS covered services to the Member during the CCS eligibility determination period who are determined to meet the CCS standards for paneling. Contractor shall inform providers, except as noted above, that CCS reimburses only CCS paneled providers. The Contractor shall submit information to the CCS program on all providers who have provided services to a Member thought to have a CCS eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Contractor network physician, via telephone, FAX, or mail. In an emergency admission, Contractor or Contractor network physician, shall be allowed until the next working day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or determined to meet the CCS standards for paneling.

10. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).

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CASE MANAGEMENT AND COORDINATION OF CARE

C. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with the Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.

D. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS waiver program administered by the State Department of Developmental Services (DDS).

If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2 for the coordination of services for Members with developmental disabilities.

11. Early Intervention Services

Contractor shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program. These include children who have a developmental delay in either cognitive, communication, social, emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary

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covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.

12. Local Education Agency Services (LEA)

Local Education Agency assessment services are services specified in 22 CCR 51360(b) and provided to students who qualify based on 22 CCR 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020, are not covered under this Contract.

However, the Contractor is responsible for providing a Primary Care Provider and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's Primary Care Physician cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

13. School Linked Children's Health and Disability Prevention (CHDP) Services

A. Coordination of Care

Contractor shall maintain a "medical home" and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

B. Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Subcontracts or other cooperative arrangements with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.

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2) Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.

3) Referral protocols/guidelines between the Contractor and the school sites, which conduct CHDP screening only, including strategies for the Contractor to follow-up and document if services are being provided to the Member, within the required State and federal time frames.

4) Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. Subcontracts

Contractor shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, Provision 12, regarding Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and grievance/complaint procedures.

14. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Program

Services provided under the HIV/AIDS Home and Community Based Services Waiver are not covered under this Contract. Contractor shall maintain procedures for identifying Members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program and shall facilitate referrals of these Members to the HIV/AIDS Home and Community Based Services Waiver Program. Contractor shall monitor and ensure the coordination of services with the Home and Community Based Waiver Program and continue to provide all medically necessary services to the member.

Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community

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Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space.

15. Dental

Dental services are not covered under this Contract. Contractor shall cover and ensure that dental screenings for all Members are included as a part of the initial health assessment. For Members under 21 years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental providers. Contractor shall cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure, including facility fees and anesthesia services for both inpatient and outpatient services. Effective on and after June 1, 2006, topical application of fluoride for children under 6 years of age, up to three times in a 12 month period, is a Medi-Cal Managed Care Plan benefit. When the procedure follows a protocol established by the attending physician, then nurses and other appropriate personnel may apply fluoride varnish.

Contractor may require Prior Authorization for medical services required in support of dental procedures. If the Contractor requires prior-authorization for these services, Contractor shall develop and publish policies and procedures for obtaining pre-authorization to ensure that services for the Members are not unduly delayed. Contractor shall submit such procedures to DHCS for review and approval.

16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

A. DOT is offered by local health departments (LHDs) and is not covered under this Contract. Contractor shall assess the risk of noncompliance for each Member who requires placement on anti-tuberculosis drug therapy.

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); Members whose treatment has failed or who have relapsed after completing a prior

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regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). Contractor shall refer Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of the Contractor's providers, a Member with one or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the LHD as stipulated in Exhibit A, Attachment 12, Provision 2, for the provision of DOT.

17. Women, Infants, and Children Supplemental Nutrition Program (WIC)

A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services. As part of the referral process, Contractor shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. Contractor shall also document the laboratory values and the referral in the Member's Medical Record.

Contractor, as part of its initial health assessment of Members, or, as part of the initial evaluation of pregnant Members, shall refer and document the referral of pregnant, breastfeeding, or postpartum Members or a parent/guardian of a child under the age of 5 to the WIC program as mandated by 42 CFR 431.635(c).

B. Contractor shall execute a Memorandum of Understanding (MOU) with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program.

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Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

18. Excluded Services Requiring Member Disenrollment

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll and receive the following services through the Medi-Cal Fee-for-Service program until the date of disenrollment is effective.

A. Long Term Care (LTC)

Long-term care is defined as care in a facility for longer than the month of admission plus one month. LTC services are not covered under this Contract. Contractor shall cover Medically Necessary nursing care provided from the time of admission and up to one month after the month of admission.

Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities, and Intermediate Care Facilities. Contractor shall base decisions on the appropriate level of care on the definitions set forth in 22 CCR 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR 51003(e).

Upon admission to an appropriate facility, Contractor shall assess the Member’s health care needs and estimate the potential length of stay of the Member. If the Member requires LTC, in the facility for longer than the month of admission plus one month, Contractor shall submit a disenrollment request for the Member to DHCS for approval. Contractor shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective.

An approved disenrollment request will become effective the first day of the second month following the month of the Member's admission to the facility, provided the Contractor submitted the disenrollment request at least 30 calendar days prior to that date. If the Contractor submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Upon the disenrollment effective date, Contractor shall ensure the Member's orderly

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transfer from the Contractor to the Medi-Cal FFS program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Contractor to the Medi-Cal FFS provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.

Admission to a nursing Facility of a Member who has elected hospice services as described in 22 CCR 51349, does not affect the Member's eligibility for Enrollment under this Contract. Hospice services are Covered Services under this Contract and are not long term care services regardless of the Member's expected or actual length of stay in a nursing Facility as described in Attachment 10, Provision 7, Subprovision B.

B. Major Organ Transplants

Except for kidney transplants, major organ transplant procedures that are Medi-Cal FFS benefits are not covered under the Contract. When a Member is identified as a potential major organ transplant candidate, Contractor shall refer the Member to a Medi-Cal approved transplant center. If the transplant center Physician considers the Member to be a suitable candidate, the Contractor shall submit a Prior Authorization Request to either the DHCS San Francisco Medi-Cal Field Office (for adults) or the California Children Services Program (for children) for approval. Contractor shall initiate disenrollment of the Member when all of the following has occurred: referral of the Member to the organ transplant facility; the facility's evaluation has concurred that the Member is a candidate for major organ transplant; and, the major organ transplant is authorized by either DHCS' Medi-Cal Field Office (for adults) or the California Children Services Program (for children).

Contractor shall continue to provide all Medically Necessary Covered Services until the Member has been disenrolled from the plan.

Upon the disenrollment effective date, Contractor shall ensure continuity of care by transferring all of the Member's medical documentation to the transplant Physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the Member was approved as a major organ transplant candidate. The request for reimbursement for services in the month during which the transplant is approved are to be sent by the provider directly to the Medi-Cal FFS fiscal

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intermediary. The capitation payment for the Member will be recovered from the Contractor by DHCS.

If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHCS denies authorization for a transplant, the Member will not be disenrolled. Contractor shall cover the cost of the evaluation performed by the Medi-Cal approved transplant center.

19. Waiver Programs

DHCS administers a number of Medi-Cal Home and Community Based Services (HCBS) Waiver programs authorized under section 1915(c) of the Social Security Act. Contractor shall have procedures in place to identify Members who may benefit from the HCBS Waiver programs, and refer them to the Long Term Care Division of HCBS Branch. These waiver programs include the In-Home Medical Care Waiver, the Nursing Facility Subacute Waiver, and Nursing Facility/Acute Hospital Waiver (NF/AH). If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled with Contractor. Contractor shall continue to cover all Medically Necessary Covered Services to the Member.

20. Immunization Registry Reporting

Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the Contractor’s Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member’s initial health assessment and all other health care visits that result in an immunization being provided. Reporting shall be in accordance with all applicable State and federal laws.

21. Erectile Dysfunction (ED) Drugs and Other ED Therapies

Erectile dysfunction drugs and other ED therapies are excluded from this Contract. These excluded drugs include all drugs used for the treatment of ED that are listed in the Medi-Cal Pharmacy Provider Manual in the Erectile Dysfunction Treatment Drug listings. The drugs listed in the Medi-Cal Pharmacy Provider Manual are not reimbursed by the Medi-Cal FFS program.

Contractor shall assist Members requiring ED drugs or therapies in locating available treatment service sites and arranging for referral for appropriate services. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the ED drugs or ED therapies and

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coordinate services between the primary care providers and the treatment programs.

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Exhibit A, Attachment 12
LHD COORDINATION

1. Subcontracts

Contractor shall negotiate in good faith and execute a Subcontract for public health services listed in A through D below with the Local Health Department (LHD) in each county that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the Local Health Department and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, Provision 12, regarding Subcontracts.

A. Family Planning Services: as specified in Exhibit A, Attachment 8, Provision 9.

B. Sexually Transmitted Disease (STD) services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 10, by DHCS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

C. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, Provision 11.

D. Immunizations: as specified in Exhibit A, Attachment 8, Provision 12.

To the extent that Contractor does not meet this requirement on or before four (4) months after the commencement of the Operations Period, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Subcontracts or Memoranda of Understanding

If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute a Subcontract with the LHD or agency as stipulated in Provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies.

A. California Children Services (CCS)

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Exhibit A, Attachment 12
LHD COORDINATION

B. Maternal and Child Health (MCH)

C. Child Health and Disability Prevention (CHDP) Program

D. Tuberculosis Direct Observed Therapy

E. Women, Infants, and Children (WIC) Supplemental Nutrition Program

F. Regional Centers for services for persons with developmental disabilities

G. Local Governmental Agencies for Targeted Case Management services.

3. Local Mental Health Plan Coordination

A. Contractor shall negotiate in good faith and execute a MOU with the local mental health plan in accordance with Welfare and Institutions Code Section 5777.5. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the mental health plan in delivering and coordinating the care of Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

1) Protocols and procedures for referrals between Contractor and the mental health plan.

2) Protocols for the delivery of Specialty Mental Health Services, including the mental health plan's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness.

3) Protocols for the delivery of mental health services within the Primary Care Physician's scope of practice.

4) Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records.

5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

a) Pharmaceutical services and prescription drugs

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Exhibit A, Attachment 12
LHD COORDINATION

b) Laboratory, radiological and radioisotope services

c) Emergency room facility charges and professional services

d) Emergency and non-emergency medical transportation

e) Home health services

f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals

6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition.

7) Procedures to resolve disputes between Contractor and the mental health plan.

4. MOU Monthly Reports

To the extent Contractor does not execute an MOU within four (4) months after commencement of the Operations Period, Contractor shall submit documentation substantiating its good faith efforts to enter into an MOU. Until such time as an MOU is executed, Contractor shall submit monthly reports to DHCS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU has not been executed.

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Exhibit A, Attachment 13
MEMBER SERVICES

1. Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, providers, and, upon request, potential members.

1) Contractor's written policies regarding Member rights shall include the following:

a) To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.
b) To be provided with information about the plan and its services, including Covered Services.
c) To be able to choose a Primary Care Provider within the Contractor's network.
d) To participate in decision making regarding their own health care, including the right to refuse treatment.
e) To voice grievances, either verbally or in writing, about the organization or the care received.
f) To receive oral interpretation services for their language.
g) To formulate advance directives.
h) To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
i) To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
j) To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
k) To disenroll upon request.
l) To access Minor Consent Services.
m) To receive written Member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).

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n) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

o) To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

p) To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

q) Freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.

2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.6(i), and Probate Code Sections 4673 to 4678 and Sections 4800 to 4806, and all applicable regulations.

2. Member Services Staff

A. Contractor shall maintain the level of knowledgeable and trained staff sufficient to provide Member services to Members or potential members and all other services covered under this Contract.

B. Contractor shall ensure Member services staff are trained on all contractually required Member or potential member service functions including, policies, procedures, and scope of benefits of this Contract.

C. Contractor shall ensure that Member Services staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with complaint and grievance resolution, access barriers, and disability issues and referral to appropriate clinical services staff.

D. Contractor shall ensure that Member Services staff will refer potential members to the DHCS enrollment broker, Health Care Options (HCO) when potential members make a request for enrollment with Contractor.

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Exhibit A, Attachment 13
MEMBER SERVICES

3. Call Center Reports

Contractor shall report quarterly, in a format to be approved by DHCS, the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and the Member services telephone calls abandonment rate.

4. Written Member Information

A. Contractor shall provide all new Members, and Potential Enrollees upon request only, with written Member information as specified in 22 CCR 53926.5. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the Covered Services including, but not limited to, health education.

B. Contractor shall distribute the Member information no later than 7 calendar days following Enrollment. Contractor shall distribute Member Information annually to each Member or family unit.

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions.

Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.

Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.

Contractor shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

D. The Member Services Guide shall be submitted to DHCS for review prior to distribution to Members. The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF)

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Exhibit A, Attachment 13
MEMBER SERVICES

as provided in 22 CCR 53920.5, 28 CCR 1300.51(d) and its Exhibit T (EOC) or U (Combined EOC/DF). In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code Section 1363, and 28 CCR 1300.63(a), as to print size, readability, and understandability of text, and shall include the following information:

1) The plan name, address, telephone number and service area covered by the health plan.

2) A description of the full scope of Medi-Cal Managed Care covered benefits and all available services including health education as prescribed in Exhibit A, Attachment 10, Provision 7 Health Education, interpretive services provided by plan personnel and at service sites, and "carve out" services and an explanation of any service limitations and exclusions from coverage, or charges for services. Include information and identify services to which the Contractor or subcontractor has a moral objection to perform or support. Describe the arrangements for access to those services.

3) Procedures for accessing Covered Services including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this Contract.

   A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

4) Compliance with the following may be met through distribution of a Provider Directory:

   The name, provider number, address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, Federally Qualified Health Centers (FQHC), Indian Health Centers). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, provider number, address and telephone number shall appear for each Physician provider:

   The hours and days when each of these Facilities is open, the services and benefits available, including which, if any, non-English languages are spoken, and the telephone number to call after

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normal business hours accessibility symbols approved by DHCS, and identification of providers that are not accepting new patients.

5) Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a provider may request a change.

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

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

8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services.

9) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR § 438.114, and that prior authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

10) Procedures for obtaining emergency health care from specified plan providers or from non-plan providers, including outside Contractor's Service Area.

11) Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.

12) Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

13) Procedures for filing a grievance or appeal with Contractor, either orally or in writing, or over the phone, including procedures for appealing decisions regarding Member's coverage, benefits, or

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relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the toll-free telephone number a Member can use to file a grievance or appeal, and title, address, and telephone number of the person responsible for processing and resolving grievances and responsible for providing assistance with completing the request. Information regarding the process shall include the requirements for timeframes to file a grievance or an appeal, and the timelines for the Contractor to acknowledge receipt of grievances, to resolve grievances, and to notify the Member of the resolution of grievances or appeals. Information shall be provided informing the Member that services previously authorized by the Contractor will continue while the grievance is being resolved.

14) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, Provision 5, Disenrollment.

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

16) Information on the Member's right to the Medi-Cal State Fair Hearing process, the method for obtaining a Hearing, the timeframe to request a Hearing, and the rules that govern representation in a Hearing. Include information on the circumstances under which an expedited State Fair Hearing is possible and information regarding assistance in completing the request, regardless of whether or not a grievance has been submitted or if the grievance has been resolved when a health care service requested by the Member or provider has been denied, deferred or modified. Information on State Fair Hearing shall also include information on the timelines which govern a Member's right to a State Fair Hearing, pursuant to Welfare and Institutions Code Section 10951 and the State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Fair Hearing. Information shall include that services previously authorized by the Contractor will continue while the State Fair Hearing is being resolved if the Member requests a Hearing in the specified timeframe.

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Exhibit A, Attachment 13
MEMBER SERVICES

17) Information on the availability of, and procedures for obtaining, services at Federally Qualified Health Centers and Indian Health Clinics.

18) 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, how to access these services, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

    Family planning services are provided to Members of childbearing 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.

19) Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

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

21) Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Exhibit A, Attachment 9, Provision 7 Nurse Midwife and Nurse Practitioner Services.

22) Information furnished on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program.

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Exhibit A, Attachment 13
MEMBER SERVICES

23) Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the Department of Managed Health Care, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

24) Information concerning the provision and availability of services covered under the California Children's Services program from providers outside Contractor's provider network and how to access these services.

25) An explanation of the expedited Disenrollment process for Members qualifying under conditions specified under 22 CCR Section 53889(j) which includes 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.

26) Information on how Minor Consent Services may be obtain through Contractor's provider network, an explanation of those services, and information on how they can also be obtained out of the Contractor's provider network.

27) An explanation on how to use Medi-Cal FFS when Medi-Cal Covered Services are excluded or limited under this Contract and how to obtain additional information.

28) An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access Indian Health Service facilities, and to disenroll from Contractor's plan at any time, without cause.

29) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to Health and Safety Code Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

30) A statement as to whether the Contractor uses provider financial bonuses or other incentives with its contracting Providers of health

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care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's medical group or independent practice association.

31) A notice as to whether the Contractor uses a drug formulary. The notice shall: (i) be in the language that is easily understood and in a format that is easy to understand; (ii) include 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; (iii) indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information; and (iv) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a particular medical condition.

32) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of State law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

33) Instructions on how a Member can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures.

34) Any other information determined by DHCS to be essential for the proper receipt of Covered Services.

E. Member Identification Card

Contractor shall provide an identification card to each Member, which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.

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Exhibit A, Attachment 13
MEMBER SERVICES

5. Member Notification of Changes in Access to Covered Services

A. Contractor shall ensure Members are notified in writing of any changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR 438.10(f)(4), at least 30 calendar days prior to the effective date of such changes. In the event of a natural disaster or emergency, Contractor shall provide notice to Members as soon as possible, but no later than 14 calendar days. The notification to Members must be presented to and approved in writing by DHCS prior to its release.

B. Pursuant to 42 CFR 438.10(f)(5), Contractor shall make a good faith effort to give written notice of termination of a contracted/subcontracted provider, within 15 days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

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Exhibit A, Attachment 13
MEMBER SERVICES

6. Primary Care Provider Selection

A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician (PCP).
   1) Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first 30 calendar days of enrollment.
   2) Contractor may allow Members to select a clinic that provides primary care.
   3) If the Contractor's provider network includes Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, the Member may select a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with Title 22 CCR Section 53853(a)(4).
   4) Contractor shall provide a mechanism for SPD beneficiaries to select a specialist or clinic that meets DHCS subcontracting requirements as stated in Attachment 6 of this contract as a Primary Care Physician if the specialist or clinic agrees to serve as a primary care provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W & I Code Section 14182 (b)(11).
   5) Contractor shall ensure that Members are allowed to change a Primary Care Physician, Nurse Practitioner, Certified Nurse Midwife or Physician Assistant, upon request, by selecting a different Primary Care Provider from Contractor's network of providers.

B. Contractor shall disclose to effected Members any reasons that their selection or change in PCP could not be made.

C. Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

D. Contractor shall ensure that Members may choose Traditional and Safety Net Providers as their Primary Care Provider.

7. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that

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Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Primary Care Providers. If, at any time, a Member notifies the Contractor of a Primary Care Provider or Subcontracting Health Plan choice, such choice shall override the Member Assignment to a Primary Care Provider or Subcontracting Health Plan.

B. If a SPD beneficiary does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use FFS utilization data or other data sources, including electronic data, to establish existing provider relationships for the purpose of Primary Care Provider assignment, including a specialist or clinic if a SPD beneficiary indicates a preference for either. Contractor shall comply with all Federal and State privacy laws in the provision and use of this data.

C. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the provider within 10 calendar days from when selection or assignment is completed by the Member or the Contractor, respectively.

D. Contractor shall maintain procedures that proportionately include contracting Traditional and Safety-Net Providers in the assignment process for Members who do not choose a Primary Care Provider.

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

B. Contractor shall ensure that at least 10 days of advanced notice is given to a Member when a Notice of Action results in a termination, suspension, or reduction of previously authorized covered services. The Contractor shall shorten the advanced notice to five (5) days if probable recipient fraud has been verified.

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Exhibit A, Attachment 13
MEMBER SERVICES

Contractor shall not be required to provide advanced notice of a termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:

1) Death of a Member;

2) Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;

3) Member admission into an institution that makes the Member ineligible for further services;

4) Member's address is unknown and mail directed to the Member has no forwarding address;

5) Member has been accepted for Medi-cal services by another local jurisdiction;

6) Member's Primary Care Physician prescribes a change in the level of medical care;

7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or

8) Safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

C. Contractor shall provide expedited advanced notice to a Member when Contractor or Primary Care Physician indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than three (3) working days after receipt of the request for services. Upon approval from DHCS, Contractor may extend the three (3) working day expedited period to 14 calendar days if the enrollee requests an extension, or if Contractor justifies a need for additional information and that the extension is in the Member's interest.

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Exhibit A, Attachment 13
MEMBER SERVICES

D. Contractor shall provide for a written notification to the Member and the Member's authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:

1) The Member's right to, method of obtaining, and time limit for requesting a fair hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.

2) The Member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend or other spokesperson.

3) The name and address of Contractor and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

B. Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the time frames set forth in 22 CCR 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

SAMPLE

Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

1. Member Grievance System

A. Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.

B. Contractor Member Grievance system consists of two steps. The first step is review at the first level. If the Member is not satisfied with resolution of the Grievance at the first level, the Member may pursue resolution of the Grievance at the secondary level, or elect a State Fair Hearing if the Grievance is one for which the Member may file for a State Fair Hearing, or pursue both concurrently. If the Member is not satisfied with resolution of the Grievance at the secondary level, the Member may either:

1) Request a State Fair Hearing if the Grievance is one for which the Member may file for a State Fair Hearing; or

2) Pursue resolution through Contractor arbitration procedure as set forth in Provision 6 below, or pursue both concurrently.

If the Member chooses to file a Grievance through Contractor's Grievance System, and the Member's Grievance is one for which the Member may request a State Fair Hearing, the Member may request a State Fair Hearing at any time during the procedures outlined in Provision 7 below, including, but not limited to, after arbitration is concluded. Contractor shall maintain and make available to DHCS a log and records as required by 22 CCR 53914.

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's Grievance system and the expedited review of grievances required under 28 CCR 1300.68 and 1300.68.01 and 22 CCR 53858.

A. Procedure to ensure timely acknowledgement, resolution, and feedback to complainant. Provide oral notice of the resolution of an expedited review.

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Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

B. Procedure to ensure a Member is given reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and a toll-free number with TTY/TDD and interpreter capability.

C. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

D. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.

E. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's Medical Director.

F. Procedure to ensure that requirements of Title 42 CFR 438.420(a)-(c) are met regarding services to Members during the grievance process.

G. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance and is a health care professional with clinical expertise in treating a Member's condition or disease if any of the following apply:

1) A denial based on lack of medical necessity;

2) A grievance regarding denial of expedited resolutions of an appeal; and

3) Any grievance or appeal involving clinical issues.

H. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. In the case of a grievance subject to expedited review, Contactor shall inform the Member of the limited time available to present evidence. Contractor shall

SAMPLE

also comply with 42 CFR 438.406(b)(3) concerning a Member's request to review records in connection with a grievance.

3. Grievance Log and Quarterly Grievance Report

A. Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in 22 CCR 53858(e).

B. Contractor shall submit quarterly grievance reports in the form that is set forth in 28 CCR 1300.68(f). The grievance report should include an explanation for each grievance that was not resolved within 30 calendar days of receipt of the grievance.

1) In addition to the types or nature of grievances listed in 28 CCR 1300.68(f)(2)(D), the report shall also include, but not be limited to, untimely assignments to a Primary Care Provider, issues related to cultural sensitivity and linguistic access, difficulty with accessing specialists, and grievances related to out-of-network requests.

2) For the Medi-Cal category of the report, provide the following additional information:

a) The total number of grievances received.
b) The average time it took to resolve grievances, which includes providing written notification to the Member.
c) A listing of the zip codes, ethnicity, gender, and primary language of Members who filed grievances.

C. Contractor shall submit reports resulting from its quarterly review and analysis of all recorded grievances as required by 22 CCR 53858(e)(4).

D. Contractor shall submit the quarterly grievance reports for the following quarters: April – June, July – September, October – December, January – March. The reports are due 30 calendar days from the date of the end of the reporting quarter.

4. Notice of Action

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Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

A. A Notice of Action (NOA) is a formal letter informing a Member that a medical service has been denied, deferred, or modified. A NOA must include all of the following:

1) The action that the MCO or its contractor has taken or intends to take;

2) The reason for the action;

3) The Member's or provider's right to file an appeal;

4) The Member's right to request a State Fair Hearing;

5) Procedures for exercising the Member's rights to appeal or grieve;

6) Circumstances under which an expedited review is available and how to request it;

7) The Member's right to have benefits continue pending the resolution of the appeal; and

8) How to request benefits be continued.

B. If a Member receives a NOA, the Member has three options:

1) Members have ninety (90) days from the date on the NOA to file an appeal of the NOA with their Plan. Members may request a State Fair Hearing regarding the NOA from the Department of Social Services (DSS) within ninety (90) days of the NOA.

2) Members may request an Independent Medical Review (IMR) regarding the NOA from the Department of Managed Health Care (DMHC). An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.

3) Members may file an appeal with their Plan regarding a NOA and request a State Fair Hearing regarding that NOA at the same time.

C. During the appeal the member must have a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member must be given the opportunity before and during the appeals process to examine his/her case file, including medical records

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and any other documents and records considered during the appeals process.

D. Member must be notified that the State must reach its decision for a standard State Fair Hearing within 90 days of the date of the request. For an expedited State Fair Hearing, the State must reach its decision with three working days of receipt of the expedited State Fair Hearing request. Contractor shall also comply with all other requirements as outlined in APL 03-009, APL 04-006, and PL 09-006, in addition to any future DHCS APL or PL.

E. Members can also file a grievance that is not about a NOA. Members must file a grievance within 180 days from the date the incident or action occurred which caused the member to be dissatisfied.

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Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

5. Member Appeal Process

Contractor shall implement and maintain an appeal process as described below to resolve Member appeals.

A. Member, or a provider acting on behalf of a Member and with the Member's written consent, may file an appeal.

B. Contractor must provide a Member notice, as expeditiously as the Member's health condition requires, within 45 days from the day Contractor receives the appeal. A Member notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Member's favor, Contractor, at a minimum must include:

1) Member's right to request a State Fair Hearing;
2) How to request a State Fair Hearing ;
3) Right to continue to receive benefits pending a State Fair Hearing; and
4) How to request the continuation of benefits.

C. Contractor may extend the timeframe to resolve an appeal by up to 14 calendar days if the Contractor shows that there is a need for additional information and how the delay is in the Member's interest.

D. Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the appeal is pending and Contractor reverses a decision to deny, limit, or delay services.

E. Contractor must pay for disputed services if the Member received the disputed services while the appeal was pending.

6. Responsibilities in Expedited Appeals

Contractor shall implement and maintain procedures as described below to resolve expedited appeals. When Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

A. Member or provider may file an expedited appeal either orally or in writing and no additional Member follow-up is required.

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Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

C. Contractor must provide a Member notice, as quickly as the Member's health condition requires, within three (3) working days from the day Contractor receives the appeal.

D. Contractor may extend the timeframe to resolve an appeal by up to 14 days if Contractor shows that there is a need for additional information and how the delay is in the Member's interest.

E. Contractor must make a reasonable effort to provide oral notice of expedited appeal decision.

7. Responsibilities in Expedited State Fair Hearings

Within two Working days of being notified by DHCS or the Department of Social Services (DSS) that a Member has filed a request for fair hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate DSS administrative law judge all information and documents which either support, or which the Contractor considered in connection with, the action which is the subject of the expedited State Fair Hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and NOA, plus any pertinent grievance resolution notice. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and grievance resolution notice. One or more plan representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited fair hearing, shall be available by phone during the scheduled State Fair Hearing. During the State Fair Hearing process, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the Hearing is pending and Contractor reverses a decision to deny, limit, or delay services. Contractor must pay for disputed services if the Member received the disputed services while the Hearing was pending.

8. Parties to an Appeal or State Fair Hearing

The parties to an appeal or the State Fair Hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased enrollee's estate.

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Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

9. Contractor Arbitration Procedure

A. Contractor employs an arbitration process for the resolution of disputes with members and uses an Office of the Independent Administrator to administer its arbitration process. Contractor shall comply with all statutory provisions relating to such arbitrations, including Health and Safety Code section 1373.20(a).

B. Except for small claims court cases and claims for which a State hearing is or may be requested pursuant to Welfare and Institutions Code section 10950 and under federal law (42 USC 1396a(d) and 42 CFR 431.200), any claim as defined herein arising from or relating to the Medi-Cal Member(s) relationship with Contractor, irrespective of the legal theory asserted, is subject to binding arbitration. For those claims for which a State hearing may be requested pursuant to Welfare and Institutions Code section 10950 and federal law, a Member must request a State hearing within 90 days after the order or action complained of. Except for administrative mandamus proceedings, the Members give up all rights to a jury or court trial for resolution of such claims. For all claims subject to Contractor's arbitration procedures, Contractor gives up all rights to a jury or court trial for resolution of such claims.

C. As used in this provision, a claim means a claim for medical or hospital malpractice, for premises liability, for coverage for, or delivery of, service pursuant to the agreement, or for violation of any duty arising from or related to the agreement.

D. The Contractor must clearly disclose the arbitration requirement in all the Contractor's Medi-Cal marketing materials, marketing presentations, advertisements and brochures whether distributed by the DHCS' enrollment contractor or otherwise, as well as the evidence of coverage and disclosure forms including a statement that Eligible Beneficiaries who enroll in Contractor's plan may be required to pay a portion of the arbitration costs incurred. DHCS shall review for approval Contractor arbitration disclosure language and marketing materials, which shall comply with all applicable laws, including Health and Safety Code section 1363.1.

E. Contractor and Member shall each pay one half the fees and expenses of the neutral arbitrator(s). However, Contractor will pay the fees and expenses of the neutral arbitrator(s) under certain conditions as set forth in 'Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator (Rules of Procedure)'. Those

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Exhibit A, Attachment 14
MEMBER GRIEVANCE SYSTEM

rules contain the following provision regarding payment of arbitrator fees and expenses:

"Health Plan shall pay for the fees and expenses incurred by the Neutral Arbitrator if:

i. Claimant(s) agrees to waive any potential objection arising out of such payment, signs the Waiver of Objection Form, and serves a copy of it on the Independent Administrator and Respondent(s); and

ii. Either the arbitration has only a single Neutral Arbitrator or the Claimant(s) has served a Waiver of Party Arbitrator Form as set out in Rule 14.d."

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this arbitration provision, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

F. Notwithstanding the above, the Member may apply for relief from the obligation to pay certain expenses incurred in connection with the arbitration in compliance with California Health and Safety Code section 1373.20.

G. All arbitration proceedings will be governed by California Welfare and Institutions Code section 14450, et seq., and approved procedures submitted by Contractor, which are in compliance with existing provisions relating to arbitration in effect on the date of the incident.

SAMPLE

Exhibit A, Attachment 15
MARKETING

1. Training and Certification of Marketing Representatives

If Contractor conducts Marketing, Contractor shall develop a training and certification program for Marketing Representatives, as described in this Exhibit A, Attachment 15, and ensure that all staff performing Marketing activities or distributing Marketing material are appropriately certified.

A. Contractor is responsible for all Marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any Marketing Representatives. Marketing staff may not provide Marketing services for more than one Contractor. Marketing Representatives shall not engage in Marketing practices that discriminate against an Eligible Beneficiary or Potential Enrollee because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.

B. Training Program

Contractor shall develop a training program that will train staff and prepare Marketing Representatives for certification. Contractor shall develop a staff orientation and Marketing representative's training/certification manual. The manual shall, at a minimum, cover the following topics:

1) An explanation of the Medi-Cal Program, including both Medi-Cal FFS and capitated contractors, and eligibility.

2) Scope of Services.

3) An explanation of the Contractor's administrative operations and health delivery system program, including the Service Area covered, excluded services, additional services, conditions of enrollment and aid categories.

4) An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency medical care through the Contractor's provider network and describing all precedents to receipt of care like referrals, prior authorizations, etc.).

5) An explanation of the Contractor's grievance procedures.

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Exhibit A, Attachment 15
MARKETING

6) An explanation of how a beneficiary disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

7) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries including information regarding eligibility under any public welfare or social services program.

8) An explanation of how Marketing Representatives will be supervised and monitored to assure compliance with regulations.

9) An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited Marketing Representative activities and conduct.

10) An explanation of the consequences of misrepresentation and Marketing abuses (i.e., discipline, suspension of Marketing, termination, civil and criminal prosecution, etc.). The Marketing Representative must understand that any abuse of Marketing requirements can also cause the termination of the Contractor's contract with the State.

11) An explanation of how a beneficiary disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

12) An explanation that discrimination in enrollment and failure to enroll a beneficiary due to a pre-existing medical condition (except for conditions requiring contract excluded services) are illegal.

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Exhibit A, Attachment 15
MARKETING

2. DHCS Approval

A. Contractor shall not conduct Marketing activities without written approval of its Marketing plan, or changes to its Marketing plan, from DHCS. In cases where the Contractor wishes to conduct an activity not included in the marketing plan, Contractor shall submit a request to include the activity and obtain written, prior approval from DHCS. Contractor must submit the written request within 30 calendar days prior to the Marketing event, unless DHCS agrees to a shorter period.

B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by DHCS prior to distribution.

C. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by DHCS prior to implementation.

3. Marketing Plan

If Contractor conducts Marketing, Contractor shall develop a Marketing plan as specified below. The Marketing plan shall be specific to the Medi-Cal program only and materials shall be distributed within the Contractor's entire service area. Contractor shall ensure that the Marketing plan, all procedures and materials, are accurate and do not mislead, confuse or defraud.

A. Contractor shall submit a Marketing plan to DHCS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe the Contractor's current Marketing procedures, activities, and methods. No Marketing activity shall occur until the Marketing plan has been approved by DHCS.

1) The Marketing plan shall have a table of contents section that divides the Marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections, or pages, when revised, can be easily identified and replaced with revised submissions.

2) Contractor's Marketing plan shall contain the following items and exhibits:

a) Mission Statement or Statement of Purpose for the Marketing plan.

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Exhibit A, Attachment 15
MARKETING

b) Organizational Chart and Narrative Description

The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.

The description shall explain how the Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and, reporting relationships including, if applicable, how the Contractor's commercial Marketing staff and functions interface with its Medi-Cal Marketing staff and functions.

c) Marketing Locations

All sites for proposed Marketing activities such as annual health fairs, and community events, in which the Contractor proposes to participate, shall be listed.

d) Marketing Activities

All Marketing methods and Marketing activities Contractor expects to use, or participate in, shall be described. Contractor shall comply with the guidelines described, as applicable, in 22 CCR 53880 and 53881, Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411, and as follows:

i. Contractor shall not engage in door to door, cold call, telephone, or other Marketing for the purpose of enrolling Members or Potential Enrollees.

ii. Contractor shall obtain DHCS approval to perform in-home Marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home Marketing presentation or a documented telephone log entry showing the request was made.

iii. Contractor shall not conduct Marketing presentations at primary care sites.

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Exhibit A, Attachment 15
MARKETING

iv. Include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.

e) Marketing Materials

Copies of all Marketing materials the Contractor will use for both English and non-English speaking populations shall be included.

Marketing materials shall not contain any statements that indicate that enrollment is necessary to obtain or avoid losing Medi-Cal benefits, or that the Contractor is endorsed by DHCS, the Centers for Medicare and Medicaid Services, or any other state or federal government entity.

A sample copy of the Marketing identification badge and business card that will clearly identify Marketing Representatives as employees of the Contractor shall be included. Marketing identification badges and business cards shall not resemble those of a government agency.

f) Marketing Distribution Methods

A description of the methods the Contractor will use for distributing Marketing materials.

g) Monitoring and Reporting Activities

Written formal measures to monitor performance of Marketing Representatives to ensure Marketing integrity pursuant to Welfare and Institutions Code Section 14408(c).

h) Miscellaneous

All other information requested by DHCS to assess the Contractor's Marketing program.

B. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

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Exhibit A, Attachment 15
MARKETING

4. Marketing Event Notification

Contractor shall notify DHCS at least 30 calendar days in advance of Contractor's participation in all Marketing events. In cases where Contractor learns of an event less than 30 calendar days in advance, Contractor shall provide notification to DHCS immediately. In no instance shall notification be less than 48 hours prior to the event.

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Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS

1. Enrollment Program

Contractor shall cooperate with the DHCS Enrollment program and shall provide to DHCS' enrollment contractor a list of network providers (Provider Directory), linguistic capabilities of the providers and other information deemed necessary by DHCS to assist Medi-Cal beneficiaries, and Potential Enrollees, in making an informed choice in health plans. The Provider Directory will be submitted every 6 months and in accordance with MMCD Policy Letter 00-02.

Contractor shall accept as Members, Medi-Cal beneficiaries in the mandatory and voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, Eligible Beneficiaries, including Medi-Cal beneficiaries in Aid Codes who elect to enroll with the Contractor or are assigned to the Contractor.

A. Enrollment – General

Eligible Beneficiaries residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.

B. Coverage

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by DHCS to Contractor.

Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother’s membership, Contractor shall provide Covered Services to the child during the mother’s first month of Enrollment. No additional capitation payment will be made to the Contractor by DHCS.

C. Exception to Enrollment

A beneficiary in a mandatory aid code category is not required to enroll when a request for an exemption under Title 22, CCR, Section 53923.5 has been approved.

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Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS

D. Enrollment Restriction

Enrollment will proceed unless restricted by DHCS. Such restrictions will be defined in writing and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) calendar days prior to the date of the release. DHCS shall immediately suspend enrollment of SPD beneficiaries if DHCS determines that Contractor does not have sufficient primary or specialty providers to meet the needs of SPD beneficiaries in accordance with W & I Code 14182(w).

E. Enrollment Capacity (only to specific contractors that choose limitations)

All Eligible Beneficiaries shall be accepted by Contractor up to the limits of Contractor's Enrollment capacity approved by DHCS.

2. Assignment of Members

If Member fails to timely choose a Primary Care Physician or a Subcontracting Health Plan, the Contractor shall notify the Member in writing of the Primary Care Physician or Subcontracting Health Plan with whom the Member will be assigned. If, at any time, a Member notifies the Contractor of a Primary Care Physician or Subcontracting Health Plan choice, such choice shall override the Member Assignment to a Primary Care Physician or Subcontracting Health Plan.

3. [Intentionally Left Blank]

4. Continuance of Membership

A Member's Enrollment shall continue unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in Provision 5. Disenrollment. Upon expiration of this Contract, Contractor shall retain its enrolled Members if prior to expiration of the Contract, Contractor renews its participation in the Geographic Managed Care program, and without a break in service, receives a new contract.

5. Disenrollment

The enrollment contractor shall process a Member Disenrollment under the following conditions, subject to approval by DHCS, in accordance with the provisions of 22 CCR 53925.5:

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Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS

A. Disenrollment of a Member is mandatory when:

1) The Member requests Disenrollment, subject to any lock-in restrictions on Disenrollment under the federal lock-in option, if applicable.

2) The Member's eligibility for Enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.

3) Enrollment was in violation of 22 CCR 53400, 53921, 53921.5, 53922 or 53402, or requirements of this Contract regarding Marketing, and DHCS or Member requests Disenrollment.

4) Disenrollment is requested in accordance with Welfare and Institutions Code, Sections 14303.1 regarding merger with other organizations, or 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.

5) There is a change of a Member's place of residence to outside Contractor's Service Area.

6) Disenrollment is based on the circumstances described in Exhibit A, Attachment 11, Provision 17 Excluded Services Requiring Member Disenrollment.

Such Disenrollment shall become effective on the first day of the second month following receipt by DHCS of all documentation necessary, as determined by DHCS, to process the Disenrollment, provided Disenrollment was requested at least 30 calendar days prior to that date, except for Disenrollments pursuant to Exhibit A, Attachment 11, Provision 18, regarding Major Organ Transplants, for which Disenrollment shall be effective the beginning of the month in which the transplant is approved.

B. Except as provided in Subprovision A, Paragraph 6, enrollment shall cease no later than midnight on the last day of the first calendar month after the Member's Disenrollment request and all required supporting documentation are received by DHCS. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any capitation payment forwarded to Contractor for persons no longer enrolled under this Contract.

C. Contractor shall implement and maintain procedures to ensure that all Members requesting Disenrollment or information regarding the

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Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS

Disenrollment process are immediately referred to the enrollment contractor.

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Exhibit A, Attachment 17

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

This Implementation Plan and Deliverables Attachment describe DHCS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning Operations, unless otherwise specified herein. Contractor is expected to update throughout the duration of the Contract.

All of the items required by this Attachment must be submitted and approved to DHCS by Contractor prior to the beginning of Operations. Further, each item must also be provided to DHCS if Contractor has already begun Operations but has not, for any reason, previously provided any of the items to DHCS. Unless specified otherwise herein, Contractor shall have a continuing obligation to update the deliverables required by this Attachment whenever the information in the deliverables changes in any material respect, or upon revision requested by DHCS. This obligation extends for the duration of this Contract; updates should be submitted to DHCS, for review and approval, within 30 days of any material change. The approval process for updates shall be in accordance with Exhibit E, Attachment 3, Provision 5. Unless expressly requested by DHCS, Contractor is not required to submit any of the items in this attachment if the item contains current information and is currently on file with DHCS. All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

The Contractor has 15 calendar days, from the effective date of this Contract, to submit a Workplan that describes in detail how and when the Contractor will submit and complete the deliverables to DHCS in accordance with the Implementation Plan and Deliverables in this Attachment. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The Contractor's Workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. DHCS will review and approve each of the Workplan(s). However, Contractor shall not delay the submission of deliverables required in the Workplan(s) while waiting for DHCS approval of previously submitted deliverables required by the Workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved DHCS Workplan(s). In the event the Contractor fails to submit all required deliverables in accordance with the milestones and timeframes in the approved DHCS Workplan(s), DHCS may impose sanctions or any other remedy available under this Contract, or applicable law.

Contractor shall submit:

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

1. Organization and Administration of Plan

Submit the following consistent with the requirements of Exhibit A, Attachment 1.

A. Submit documentation of employees (current and former State employees) who may present a conflict of interest.

B. Submit a complete organizational chart.

C. Submit the following Knox-Keene license exhibits and forms found in 28 CCR 1300.51 et seq reflecting current operation status:

1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.

a) Corporation: Exhibits F-1-a-i through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A.
b) Partnership: Exhibits F-1-b-i and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B.
c) Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C.
d) Other Organization: Exhibits F-1-d and F-1-d-ii, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships, Form HP 1300.51-D.
e) Public Agency: Exhibits F-1-e-I through F-1-e-iii.

28 CCR 1300.51(d)F1a – e

2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above.

28 CCR 1300.51(d)F1f

3) Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal Creditors and Providers of Administrative Services.

28 CCR 1300.51(d)F2

4) Exhibit F-3 Other Controlling Persons.

28 CCR 1300.51(d)F

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

5) In addition to Exhibits F, Contractor shall demonstrate compliance with requirements of 22 CCR 53874 and 53600. Identify any individual named in this item b. that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.

D. Submit Exhibits N-1 and N-2: Contracts for Administrative Services.

28 CCR 1300.51(d)N1&2

E. Contractor shall submit policies and procedures for ensuring that all appropriate staff receives sensitivity training relating to SPD beneficiaries.

2. Financial Information

Submit the following consistent with the requirements of Exhibit A, Attachment 2.

A. Submit most recent audited annual financial reports.

B. Submit quarterly financial statements with the most recent quarter prior to execution of the Contract.

C. Submit the following Knox-Keene license exhibits reflecting projected financial viability:

1) Exhibit HH-1
2) Exhibit HH-2
(28 CCR 1300.76)
3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.

D. Submit Knox-Keene license Exhibit HH-6. Include the following:

1) Exhibit HH-6-a
2) Exhibit HH-6-b
3) Exhibit HH-6-c
4) Exhibit HH-6-d
5) Exhibit HH-6-e

29 CCR 1300.51(d)(HH)

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IMPLEMENTATION PLAN AND DELIVERABLES

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 22 CCR 53863 and 53868.

F. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:

1) Exhibit II-1
2) Exhibit II-2
3) Exhibit II-3

28 CCR 1300.51(d)(II)

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.

28 CCR 1300.70(b)(2)(H)1. 22 CCR 53250.

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.

I. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

3. Management Information System (MIS)

Submit the following consistent with the requirements of Exhibit A, Attachment 3.

A. Submit a completed MCO Baseline Assessment Form

B. When procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:

1) Outline of the tasks required;
2) The major milestones;

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Exhibit A, Attachment 18
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3) The responsible party for all related tasks;
4) A full description of the acquisition of software and hardware, including the schedule for implementation;
5) Full documentation of support for software and hardware by the manufacturer or other contracted party;
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;
7) Documentation of system changes related to the Health Insurance Portability and Accountability Act of 1996 requirements.

C. Submit a detailed description of how Contractor will monitor the flow of encounter data from provider level to the organization.

D. An Encounter data test produced from real or dummy data processed by the MIS must be submitted. Monthly encounter submissions may not take place until this test has been successfully completed.

E. Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.

F. Submit a work plan for compliance with the Health Insurance Portability and Accountability Act of 1996.

G. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.

H. Contractor's MIS will be reviewed against the model MIS Guidelines. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems:

1) Financial
2) Member/Eligibility
3) Provider
4) Encounter/Claims
5) Quality Management/Utilization

I. Submit a sample and description of the following reports generated by the MIS:

1) Member roster
2) Provider Listing
3) Capitation payments

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Exhibit A, Attachment 18
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4) Cost and Utilization
5) System edits/audits
6) Claims payment status/processing
7) Quality Assurance
8) Utilization
9) Monitoring of Complaints

4. Quality Improvement System (QIS)

Submit the following consistent with the requirements of Exhibit A, Attachment 4.

A. Submit a written description of the QIS, including:

1) A flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.
2) A description of the responsibility of the Governing Body in the QIS.
3) A description of the QI Committee, including Membership, activities, roles and responsibilities.
4) A description of how providers will be kept informed of the written QIS, its activities and outcomes.
5) A description of how Plan reports any disease or condition to public health authorities.

B. Submit policies and procedures related to the delegation of the QIS activities.

C. Submit boilerplate Subcontract language showing accountability of delegated QIS functions and responsibilities.

D. Policies and procedures to address how the Contractor will meet the requirements of:

1) External Accountability Set (EAS) Performance Measures
2) Quality Improvement Projects
3) Consumer Satisfaction Survey

E. Policies and procedures for performance of Facility Site and Medical Record reviews (FSR Attachments A and B), and for performance of Facility Site Physical Accessibility reviews (FSR Attachment C).

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F. A list of sites to be reviewed prior to initiating plan operation, existing or in expanded areas.

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

G. The aggregate results of pre-operational, existing or in expanded areas, site review to DHCS at least 6 weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHCS.

H. Policies and procedures for credentialing and re-credentialing.

5. Utilization Management (UM)

Submit the following consistent with the requirements of Exhibit A, Attachment 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:

1) Procedures for pre-authorization, concurrent review, and retrospective review.
2) A list of services requiring prior authorization and the utilization review criteria.
3) Procedures for the utilization review appeals process for providers and Members.
4) Procedures that specify timeframes for medical authorization.
5) Procedures to detect both under- and over-utilization of health care services.

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

Submit the following consistent with the requirements of Exhibit A, Attachment 6.

A. Submit a complete provider network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries, including SPD beneficiaries, in the Service Area.

B. Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.

C. Submit policies and procedures regarding physician supervision of non-physician medical practitioners.

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D. Submit policies and procedures for providing emergency services.

E. Submit a complete list of specialists by type within the Contractor's network.

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 consistent with Exhibit A, Attachment 6, Provision 7.

G. Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in Exhibit A, Attachment 6, Provision 8 of the Contract.

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.

I. Submit policies and procedures for how Contractor will ensure network provider hours of operation are no less than the hours of operation offered to other commercial or FFS patients.

J. Submit a report containing the names of all subcontracting provider groups (see Exhibit A, Attachment 6, Provision 11).

K. 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.

L. Submit all boilerplate Subcontracts, signature page of all Subcontracts, and reimbursement rates. DHCS will maintain the confidentiality of the rates to the extent provided by State law.

M. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.

7. Provider Relations

Submit the following consistent with the requirements of Exhibit A, Attachment 7.

A. Submit policies and procedures for provider grievances.

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Exhibit A, Attachment 18
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B. Submit protocols for payment and communication with non-contracting providers.

C. Submit copy of Provider Manual.

D. Submit policies and procedures for ensuring providers receive training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for SPD beneficiaries.

8. Provider Compensation Arrangements

Submit the following consistent with the requirements of Exhibit A, Attachment 8.

A. Submit description of any physician incentive plans.

B. Submit policies and procedures for processing and payment of claims.

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.

D. Submit Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service Facilities Subcontracts.

E. Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).

F. Submit schedule of per diem rates and/or Fee-for-Service rates for each of the following provider types:

1) Primary Care Providers
2) Medical Groups and Independent Practice Associations
3) Specialists
4) Hospitals
5) Pharmacies

9. Access and Availability

Submit the following consistent with the requirements of Exhibit A, Attachment 9.

A. Submit policies and procedures that include requirements for:

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1) Appointment scheduling
2) Routine specialty referral
3) First prenatal visit
4) Waiting times
5) After-hours calls
6) Specialty services

B. Submit policies and procedures for ensuring the timely provision of access standards for:

2) Appropriate clinical timeframes
3) Standards for timely appointments
4) Shortening or expanding timeframes
5) Arranging timely appointments with a provider shortage.

C. Submit policies and procedures for the timely referral and coordination of Covered Services to which the Contractor or subcontractor has objections to perform or otherwise support, consistent with Exhibit A, Attachment 9, Provision 5.

D. Submit policies and procedures for standing referrals.

E. Submit policies and procedures regarding 24-hours-a-day access without prior authorization, follow-up and coordination of emergency care services.

F. Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.

G. Submit policies and procedures regarding access for disabled Members pursuant to the Americans with Disabilities Act of 1990.

H. Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.

I. Submit a written description of the Cultural and Linguistic Services Program, required by Exhibit A, Attachment 9, Provision 13. Include policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors, as well as policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

J. Submit policies and procedures for the provision of 24-hour-a-day interpreter services at all provider sites.

K. Submit policies and procedures for providing medically necessary services through out-of-network providers, including allowing access for the completion of covered services by an out-of-network or terminated provider.

L. Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a provider.

10. Scope of Services

Submit the following consistent with the requirements of Exhibit A, Attachment 10.

A. Submit policies and procedures for ensuring the provision of:

1) The Initial Health Assessment (IHA)
2) The Individual Health Education Behavioral Assessment (IHEBA).

B. Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including use of the Member Evaluation Tool (MET) and other health information used for risk stratification.

C. Submit Contractor's risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.

D. Submit the plan's risk assessment tool to be used to comprehensively assess an SPD beneficiaries' current health risk and help develop individualized care management plans.

E. Submit policies and procedures, including standards, for the provision of the following services for Members under age 21 years of age:

1) Preventive services
2) Immunizations
3) Blood Lead screens
4) Screening for Chlamydia
5) EPSDT supplemental services

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Exhibit A, Attachment 18
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F. Submit policies and procedures for the provision of adult 21 years and older, preventive services, including immunization.

G. Submit policies and procedures for the provision of services to pregnant Members, including:

1) Prenatal care
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

H. Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.

I. Provide a detailed description of the 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.

J. Submit a list and schedule of all health education programs (including classes) that are provided either directly or via subcontract by the plan.

K. Submit policies and procedures for the application and use of the Health Information Form (HIF) data submitted through the Member Evaluation Tool (MET).

L. Submit policies and procedures for the provision of:

1) Hospice care
2) Vision care – Lenses
3) Mental health services
4) Tuberculosis services

M. Submit standards and guidelines for the provision of Pharmaceutical services and prescribed Drugs.

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Exhibit A, Attachment 18
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N. Submit a complete drug formulary.

O. Submit a process for review of drug formulary.

P. Submit policies and procedures for conducting drug utilization reviews.

11. Case Management Including Coordination of Care

Submit the following consistent with the requirements of Exhibit A, Attachment 11.

A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case Management.

B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case management services.

C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and coordination of care.

D. Submit policies and procedures for ensuring the provision of Discharge Planning.

For the remaining items (E. – X.), if these items are included in the Provider Manual, submitted under item 7.D, provide a table/list of where the items can be found in the Provider Manual. Otherwise, submit each item as listed below and include a description of how they are communicated to network providers.

E. Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management provider.

F. Submit policies and procedures for the referral of Members under the age of 21 years that require complex case management services.

G. Submit policies and procedures for administration of a disease management program, including policies and procedures for identification and referral of Members eligible to participate in the disease management program.

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

H. 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.

I. Submit policies and procedures for resolving disputes between Contractor and the local mental health plan.

J. 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.

K. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

L. Submit policies and procedures for identifying and referring children with California Children Services (CCS)-eligible conditions to the local CCS program.

M. 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 Department of Developmental Services (DDS)-administered Home and Community Based Waiver program. Include the duties of the Regional Center Liaison.

N. 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.

O. Submit policies and procedures for case management coordination of care of Local Education Agency (LEA) services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.

P. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

Q. 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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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

R. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.

S. Submit policies and procedures for identification and referral of Members eligible to participate in the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome Home and Community Based Waiver Program.

T. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.

U. Submit policies and procedures for coordination of care and case management of Members with the Local Health Department (LHD)/Tuberculosis (TB) Control Officer.

V. 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.

W. Procedures to identify and refer eligible Members for Women, Infants, and Children Program (WIC) services.

X. Submit policies and procedures for assisting Members eligible for the following services:

1) Long-term care
2) Major organ transplants
3) Federal Medicaid Waiver programs

Y. Submit policies and procedures for assessment of transitional needs of Members into and out of Complex Case Management services:

1) At the request of PCP or Member
2) Achievement of targeted outcomes
3) Change of healthcare setting
4) Loss or change in benefits
5) Member non-compliance

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

12. Local Health Department Coordination

Submit the following consistent with the requirements of Exhibit A, Attachment 12.

A. Submit executed Subcontracts or documentation substantiating Contractor's efforts to enter into Subcontracts with the Local Health Department (LHD) for the following public health services:

1) Family planning services
2) Sexually Transmitted Disease (STD) services
3) Human Immunodeficiency Virus (HIV) testing and counseling
4) Immunizations

B. Submit executed Subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:

1) California Children Services (CCS)
2) Maternal and Child Health
3) Child Health and Disability Prevention Program (CHDP)
4) Tuberculosis Direct Observed Therapy
5) Women, Infants, and Children Supplemental Nutrition Program (WIC)
6) Regional Centers for services for persons with developmental disabilities.
7) Local Governmental Agencies for Targeted Case Management services.

C. Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the local mental health plan.

13. Member Services

Submit the following consistent with the requirements of Exhibit A, Attachment 13.

A. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.

B. Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that

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ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient, or non-English speaking.

C. Submit policies and procedures for addressing advance directives.

D. Submit policies and procedures for the training of Member Services staff.

E. Submit policies and procedures regarding the development content and distribution of information to Members. Address appropriate reading level and translation of materials.

F. Submit final draft of Member Identification Card and Member Services Guide (Evidence of Coverage and Disclosure Form).

G. Submit policies and procedures for Member selection of a primary care physician or non-physician medical practitioner. Include the mechanism used for allowing SPD beneficiaries to request a specialist to serve as their PCP.

H. Submit policies and procedures for Member assignment to a primary care physician. Include the use of FFS utilization data and other data in linking a SPD beneficiary to a PCP.

I. Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within ten days.

J. 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.

K. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.

14. Member Grievance System

Submit the following consistent with the requirements of Exhibit A, Attachment 14.

A. Submit policies and procedures relating to Contractor's Member Grievance system.

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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.

C. Submit format for Quarterly Grievance Log and Report.

D. Submit policies and procedures relating to Contractor's Member Appeals process. Include Contractor's responsibilities in expedited Appeals and State Fair Hearings.

15. Marketing

Submit the following consistent with the requirements of Exhibit A, Attachment 15.

A. Submit Contractor's marketing plan, including training program and certification of marketing representatives.

B. Submit a copy of boilerplate request form used to obtain DHCS approval of participation in a marketing event.

16. Enrollments and Disenrollments

Submit the following consistent with the requirements of Exhibit A, Attachment 16.

A. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.

B. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.

C. Submit policies and procedures relating to Member disenrollment.

17. Confidentiality of Medical Information

Submit the following consistent with the requirements of Exhibit E, Attachment 2, Provision 19.

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Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

A. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.

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Exhibit B
BUDGET DETAIL AND PAYMENT

1. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor shall not be obligated to perform any provisions of this Contract. Further, should funding for any fiscal year be reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to:

1) Cancel this Contract with no liability occurring to the State and no further obligation by Contractor to perform, or

2) Offer an Agreement amendment to Contractor to reflect the reduced amount.

B. All payments and rate adjustments are subject to appropriations of Medi-Cal funds by the Legislature and may require Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

2. Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

3. Contractor Risk In Providing Services

Contractor will assume the total risk of providing the Covered Services on the basis of the periodic capitation payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by the Contractor after having fulfilled obligations under this Contract will be retained by the Contractor.

4. Capitation Rates

A. DHCS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHCS. The capitation rate shall be the amount specified below. The payment period for health care services shall commence on

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Exhibit B
BUDGET DETAIL AND PAYMENT

the first day of the Operations Period, as determined by DHCS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates at the end of the month for the month of service:

Commencing Month X, 20XX:

Aid Group	Rates
Adult and Family	
Aged/Disabled Medi-Cal	
Disabled Dual	
Aged Dual	
Breast and Cervical Cancer Treatment Program (BCCTP)	

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered under this Contract. Contractor agrees to continue providing Covered Services to the Members at the monthly capitation rate specified for the original aid code. DHCS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

C. Pursuant to 438.6(c)(2)(ii), the actuarial basis for the computation of the capitation payment rates shall be set forth in DHCS' most recent version of the annually-published Rate Manual for the rate period that is identified above. Said Rate Manual is incorporated by reference in Exhibit E, Provision 1.

5. Capitation Rates Constitute Payment In Full

The capitation rates for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full subject to any stop loss reinsurance on behalf of a Member for all Covered Services required by the Member and for all Administrative Costs incurred by the Contractor in providing or arranging for those services. DHCS is not responsible for making payments for recoupment of losses.

6. Determination of Rates

A. DHCS shall determine the capitation rates for the initial period of Operations, through the duration of the Contract. DHCS shall make an

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BUDGET DETAIL AND PAYMENT

annual redetermination of rates in accordance with Title 22 CCR Sections 53321 and 53322 for each rate year defined as the 12-month period from January 1 through December 31. DHCS reserves the right to establish rates on an actuarial basis for each rate year. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Once DHCS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through a change order to this Contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements, subject to the following provisions:

1) The change order shall be effective as of January 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that a change order may not be processed in time to permit payment of new rates commencing January 1, the payment to Contractor shall continue at the rates then in effect. Those continued payments shall constitute interim payment only. Upon final approval of the change order providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval of the new rates.

b) Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be

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withheld from successive capitation payments until the overpayment is fully recovered by the State.

4) If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for rate years subsequent to January 1, 20XX resulting from a rate change pursuant to this Provision 6 or Provision 7 below, Contractor shall retain the right to terminate the Contract, in accordance with Exhibit E, Attachment 2, Provision 13, Termination. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, Provision 13, regarding Termination. DHCS shall pay the capitation rates last offered for that rate period until the Contract is terminated.

5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Provision 7, below at the earliest possible time prior to implementation of the new rate.

7. Redetermination of Rates - Obligation Changes

The capitation rates may be adjusted during the rate year to provide for a change in obligations that results in an increase or decrease of more than one percent of cost (as defined in Title 22 CCR Section53322) to the Contractor. Any adjustments shall be effectuated through a change order to the Contract subject to the following provisions:

A. The change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.

B. In the event DHCS is unable to process the change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the change order providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially

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Exhibit B
BUDGET DETAIL AND PAYMENT

alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor. DHCS shall pay the capitation rates last offered for that rate period until the Contract is terminated.

8. Reinsurance

Contractor may obtain reinsurance (stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract. Pursuant to Title 22 CCR Section 53252 (a)(2)(A)&(B), reinsurance shall not limit Contractor's liability below $5,000 per Member for any 12-month period as specified by DHCS, and Contractor may obtain reinsurance for the total cost of services provided to Members by non-contractor emergency service providers and for 90 percent of all costs exceeding 115 percent of its income during any Contractor fiscal year.

9. Catastrophic Coverage Limitation

DHCS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to Members, which results from or is greatly aggravated by, a catastrophic occurrence or disaster. Contractor will return a prorated amount of the capitation payment following the DHCS Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total capitation payment by the number of days in the month. The amount will be returned to DHCS for each day in the month after the Director has invoked the Catastrophic Coverage Limitation clause.

10. Financial Performance Guarantee

Contractor shall provide satisfactory evidence of and maintain Financial Performance Guarantee in an amount equal to at least one month's capitation payment, in a manner specified by DHCS. At the Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of

SAMPLE

this Contract or unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to Financial Performance guarantee, shall be as specified in 22 CCR 53865.

11. Recovery Of Capitation Payments

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

A. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area, or should have been disenrolled with an effective date in a prior month, DHCS may recover the capitation payments made to Contractor for the Member for the month(s) in question. In such event, Contractor may seek to recover any payments made to providers for Covered Services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question shall be paid by DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

   Upon request by Contractor, DHCS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision 18, Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHCS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, Provision 3, Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. DHCS may recover the amounts disallowed by DHHS by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

SAMPLE

Exhibit B
BUDGET DETAIL AND PAYMENT

C. If DHCS determines that an improper payment was received by Contractor for any reason not referenced in Subprovision A or B, which may include, but is not limited to, error, mistake, omission, inadvertence, delay or neglect on the part of DHCS or other entity or person, DHCS may recover the amounts determined by an offset to the capitation payments made to Contractor in accordance with Welfare and Institutions Code Section 14115.5. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. At least 30 days prior to seeking such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by DHCS.

12. Supplemental Maternity Payment

A. Contractor shall be entitled to receive a Supplemental Maternity Payment for Members enrolled with the Contractor on the date of delivery of a child, including retroactive enrollments.

B. The Supplemental Maternity Payment reimburses the Contractor for the cost of Delivery. The Supplemental Maternity Payment is in addition to the monthly Capitation Rate paid by DHCS to the Contractor for the Member.

C. Contractor must maintain on file evidence of payment of the Delivery. Failure to have supporting records may, upon audit, result in recoupment of the Supplemental Maternity Payment by DHCS.

1) Contractor shall submit data for the Supplemental Maternity Capitation Payment as specified in Exhibit A, Attachment 3, Provision 6.

2) When birth notification data is received:

a) Within fifteen months of the Delivery date of a child (or children) born to a Member, the Contractor will receive the full Supplemental Maternity Payment.

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Exhibit B
BUDGET DETAIL AND PAYMENT

b) After the fifteenth month following the month of the Delivery date of a child (or children) born to a Member, the Contractor will not receive a Maternity Capitation Payment.

SAMPLE

Exhibit C
GENERAL TERMS AND CONDITIONS

The General Terms and Conditions (GTC 307) can only be viewed or downloaded from the following internet site:

www.ols.dgs.ca.gov/standard+language/default.htm

If you do not have internet access and would like a copy of this document, please contact the California Medical Assistance Commission.

Exhibit D
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

B. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

C. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as

amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. The Contractor will include the Provisions of Paragraphs A through G in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each

subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3. Federal Contract Funds

A. It is mutually understood between the parties that this Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Contract were executed after that determination was made.

B. This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Contract. In addition, this Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress that may affect the provisions, terms or funding of this Contract in any manner.

C. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Contract shall be amended to reflect any reduction in funds.

D. DHCS has the option to invalidate or cancel the Contract with 30-days advance written notice or to amend the Contract to reflect any reduction in funds.

Exhibit D
SPECIAL TERMS AND CONDITIONS

4. Confidentiality of Information

A. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person.

B. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Contract.

C. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. The Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Contract or incorporated into this Contract by reference.

5. Human Subjects Use Requirements

By signing this Contract, Contractor agrees that if any performance under this Contract or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

6. Novation Requirements

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SPECIAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this Contract]

7. Debarment and Suspension Certification

A. By signing this Contract, the Contractor agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this Contract, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein; and

4) Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

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C. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Contract for cause or default.

8. Smoke-Free Workplace Certification

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

C. By signing this Contract, Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

D. Contractor further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

9. Covenant Against Contingent Fees

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SPECIAL TERMS AND CONDITIONS

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Contract upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this Contract without liability or in its discretion to deduct from the Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

10. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

11. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this Contract if made with a corporation for its general benefits.

12. Prohibited Use of State Funds for Software

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

13. Alien Ineligibility Certification

By signing this Contract, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et seq.)

14. Lobbying Restrictions and Disclosure Certification

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one

Exhibit D
SPECIAL TERMS AND CONDITIONS

page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

   a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

   b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

   c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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B. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

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STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

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CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐ contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: ☐ bid/offer/application initial award post-award	3. Report Type: ☐ initial filing material change For Material Change Only: Year _____ quarter_____ date of last report_____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier _____, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable: _____
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(attach Continuation Sheets(s) SF-LLL-A, If necessary)

11. Amount of Payment (check all that apply): $_____ ☐ actual ☐ planned	13. Type of Payment (check all that apply): ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature_____ Value _____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐ Yes ☐ No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

Exhibit E
ADDITIONAL PROVISIONS

1. Additional Incorporated Exhibits

The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

1) Exhibit A	**Scope of Work**
	Attachment 1 – Organization and Administration of the Plan
	Attachment 2 – Financial Information
	Attachment 3 – Management Information System
	Attachment 4 – Quality Improvement System
	Attachment 5 – Utilization Management
	Attachment 6 – Provider Network
	Attachment 7 – Provider Relations
	Attachment 8 – Provider Compensation Arrangements
	Attachment 9 – Access and Availability
	Attachment 10 – Scope of Services
	Attachment 11 – Case Management and Coordination of Care
	Attachment 12 – Local Health Department Coordination
	Attachment 13 – Member Services
	Attachment 14 – Member Grievance System
	Attachment 15 – Marketing
	Attachment 16 – Enrollments and Disenrollments
	Attachment 17 – Intentionally Left Blank
	Attachment 18 – Implementation Plan and Deliverables
2) Exhibit B	**Budget Detail and Payment**
3) Exhibit C *	**GTC 307* General Terms and Conditions:** Notwithstanding Provisions 15 and 18, which do not apply to this Contract.
	CCC 307* Attachment 1 – Certifications: Notwithstanding Provisions 4, 5, 7 and 8, which do not apply to this Contract.
	CCC 307* Attachment 2 – Doing Business with the State of California: Notwithstanding Provisions 4 and 6, which do not apply to this Contract

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Exhibit E
ADDITIONAL PROVISIONS

4) Exhibit D	**Special Terms and Conditions** Notwithstanding Provisions 6, which does not apply to this Contract.
5) Exhibit E	**Additional Provisions**
	Attachment 1 – Definitions
	Attachment 2 – Program Terms and Conditions
	Attachment 3 – Duties of the State
6) Exhibit F	**Contractor's Release**
7) Exhibit G	**Health Insurance Portability and Accountability Act**
Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this Contract as if attached hereto. *These documents can be viewed at http://www.ols.dgs.ca.gov/Standard+Language/default.htm.*	

2. Additional Provisions

In the event of a conflict between the provisions of Exhibit E and any other part of this Contract, the provisions of Exhibit E shall prevail.

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Exhibit E, Attachment 1
DEFINITIONS

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

Administrative Costs means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Advance Directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

AIDS Beneficiary means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.

Ambulatory Care means the type of health services that are provided on an outpatient basis.

Appeal means a request for review of one of the following actions:

a. A denial or limited authorization of a requested service, including the type or level of service;

b. A reduction, suspension, or termination of a previously authorized service;

c. A denial, in whole or in part, of payment for a service;

d. Failure to provide services in a timely manner; or

e. Failure to act within the timeframes provided in 42 CFR 438.408(b)

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised

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Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Beneficiary Assignment means the act of Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, Provision 2.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients that is used by Contractors and providers to verify Medi-Cal eligibility and health plan enrollment.

California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

California Children Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41800.

California Children Services (CCS) Program means the public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

Care Coordination means services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Catastrophic Coverage Limitation means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

Children with Special Health Care Needs (CSHCN) are defined as children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount

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Exhibit E, Attachment 1
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beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42 CFR s 438.208(b)(3) and (b)(4), and 438.208(c)(2), (c)(3), and (c)(4)."

Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Clean Claim means a claim that can be processed without obtaining additional information form the provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

Complex Case Management means the systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Comprehensive Medical Case Management Services means services provided by a Primary Care Provider, in collaboration with the Contractor, to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Confidential Information means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

Contract means this written agreement between DHCS and the Contractor.

Coordinate Benefits means the process of utilizing third party liability resources to ensure that the Medi-Cal program is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of Medicare or private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

Corrective Actions means specific identifiable activities or undertakings of the Contractor that address program deficiencies or problems.

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Cost Avoid means Contractor requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.

County Department means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

County Organized Health System (COHS) means a Medi-Cal Managed Care plan serving either a single or multiple-county area.

Covered Services means Medical Case Management and those benefits set forth in 22 CCR Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17 CCR Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

A. Home and Community Based Services (HCBS) as specified in Exhibit A, Attachment 11, Provisions 13 and 18 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. HCBS do not include any service that is available as an EPSDT service, including EPSDT supplemental services, as described in 22 CCR Sections 51184, 51340 and 51340.1. EPSDT supplemental services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services.

B. California Children Services (CCS) as specified in Exhibit A, Attachment 11, Provision 8.

C. Specialty Mental health services as specified in Exhibit A, Attachment 10, Provision 7.

D. Short-Doyle/Medi-Cal Mental Health Services.

E. Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider.

F. Alcohol and substance abuse treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, Provision 6.

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G. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, Provision 7.

H. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, Provision 15.

I. Dental services as specified in 22 CCR 51307 and EPSDT supplemental dental services as described in 22 CCR 51340.1(a). However, Contractor is responsible for all medical Covered Services necessary to support dental services provided to Members as specified in Exhibit A, Attachment 11, Provision 14 regarding dental services.

J. Services in any federal or State governmental hospital.

K. Any Local Education Agency (LEA) services as specified in 22 CCR 51360 and 51190.4 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in 22 CCR 51360.

L. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHCS.

M. Adult Day Health Care pursuant to 22 CCR 54001.

N. Pediatric Day Health Care pursuant to 22 CCR 51184(j).

O. Personal Care Services as defined in 22 CCR 51183 and 51350.

P. State Supported Services.

Q. Targeted case management services as specified in 22 CCR 51185 and 51351, and as described in Exhibit A, Attachment 11, Provision 2.

R. Childhood lead poisoning case management provided by Local County health departments.

S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual, MCP: GMC (Geographic Managed Care), Capitated/ Noncapitated Drugs section, which lists excluded psychiatric drugs.

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T. Human Immunodeficiency Virus (HIV) and AIDS drugs that are listed in the Medi-Cal Provider Manual, MCP: GMC (Geographic Managed Care), Capitated/Noncapitated Drugs section, which lists excluded HIV/AIDS drugs.

U. Services rendered under the Multipurpose Senior Services Program pursuant to Chapter 5 (commencing with Section 94000) of Part 1 of Division 8.5 of the Welfare and Institutions Code.

V. Except as set forth in Attachment 3.1.B.1 (effective 01/01/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code section 14133.23, effective January 1, 2006, drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC 1395w-101 et seq.) are not a Covered Service under this Contract.

W. Optional benefits as set forth in Welfare and Institutions Code Section 14131.10, as implemented by the Medi-Cal Fee-For-Service Program.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Delivery means a live birth(s) that generates a Vital Record(s) for the State of California.

Department of Health and Human Services (DHHS) means the federal agency responsible for management of the Medicaid program.

Department of Health Care Services (DHCS) means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Department of Mental Health (DMH) means the State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.

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Diagnosis of AIDS means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

Director means the Director of the State of California Department of Health Care Services.

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disproportionate Share Hospital (DSH) means a health Facility licensed pursuant to Chapter 2, Division 2, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code Section 14105.98.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 47, 54, 59, 72, 82, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 7A, 7X, 8P, 8R	03, 04, 06, 40, 42, 45, 46, 4A, 4F, 4G, 4K, 4M, 5K, 7J
Disabled/Medi-Cal Only	20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V	
Aged/Medi-Cal Only	10, 14, 16, 1E, 1H	
Adult		86

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Breast and Cervical Cancer Treatment Program (BCCTP)		0N, 0P
Disabled/Dual Eligible		20, 24, 26, 2E, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V
Aged/Dual Eligible		10, 14, 16, 1E, 1H, 2H

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in any of the following:

A. Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy.

B. Serious impairment to bodily function.

C. Serious dysfunction of any bodily organ or part.

Emergency Services means inpatient and outpatient covered services that are furnished by a provider that is qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Encounter means any single medically related service rendered by a medical provider(s) to a Member enrolled in the health plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

External Accountability Set (EAS) means a set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.

External Quality Review Organization (EQRO) means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a State's Medicaid managed care plans.

Facility means any premise that is:

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A. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract, or

B. Maintained by a provider to provide services on behalf of the Contractor.

Federal Financial Participation (FFP) means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act. (42 USC 1396d(l)(2)(B).)

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC §300e).

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under this Contract.

Fee-For-Service Medi-Cal Mental Health Services (FFS/MC) means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's capitation.

Financial Statements means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the federal Fiscal Year is October 1 through September 30.

Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or appeal made by a Member. In the case of a Grievance that constitutes an "appeal" under 42 CFR 438.400(b), the provider must have the Member's written consent before filing the Grievance on behalf of the Member.

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Health Maintenance Organization (HMO) means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

Health Plan Employer Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

Indian Health Service (IHS) Facilities means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area. (See 22 CCR 55000.)

Intermediate Care Facility (ICF) means a Facility which is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in 22 CCR 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health and Safety Code.

Marketing means any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade or influence Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

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Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to potential enrollees.

Marketing Representative means a person who is engaged in Marketing activities on behalf of the Contractor.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

Medical Home means a place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support case management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I 14182(c)(13)(B).

Medical Records means written documentary evidence of treatments rendered to Contractor's Members.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 22 CCR 51340 and 51340.1.

Member means any Eligible Beneficiary who is enrolled with Contractor. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member".

Member Evaluation Tool (MET) means the information collected from a health information form completed by beneficiaries at the time of enrollment by which they may

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self-identify disabilities, acute and chronic health conditions, and transitional service needs. Contractor shall receive the MET from the enrollment broker with the enrollment file and shall use the MET for early identification of members' healthcare needs. For newly enrolled SPD beneficiaries Contractor must use the MET as part of the health risk assessment process.

Minimum Performance Level refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

A. Sexual assault, including rape.

B. Drug or alcohol abuse for children 12 years of age or older.

C. Pregnancy.

D. Family planning.

E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

NCQA Licensed Audit Organization is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

Newborn Child means a child born to a Member during her membership or the month prior to her membership.

Non-Emergency Medical Transportation means ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR Sections 51323, 51231.1, and 51231.2, rendered by licensed providers.

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Non-Medical Transportation means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

Non-Physician Medical Practitioners (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

Not Reported means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

Nurse means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Other Healthcare Coverage (OHC) means coverage for health related services or entitlements for which an Eligible Beneficiary is eligible under private health plan, any indemnification insurance program, any other State or federal medical care program, or under other contractual or legal entitlement. The responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Outpatient Care means treatment provided to a Member who is not confined in a health care Facility.

Pediatric Subacute Care means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical Necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.

Person-Centered Planning means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning.

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Physician means a person duly licensed as a Physician by the Medical Board of California.

Physician Incentive Plan means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

Policy Letter means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation, but does not add new obligations to the contract.

Post-Payment Recovery means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Post-stabilization Services means Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.

Potential Enrollee means a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.

Preventive Care means health care designed to prevent disease and/or its consequences.

Primary Care means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Physician (PCP) means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182 (b)(11).

Primary Care Provider means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining

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the continuity of patient care. A Primary Care Provider may be a Primary Care Physician (PCP) or Non-Physician Medical Practitioner.

Prior Authorization means a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

Provider means a Physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Provider Grievance means an oral or written expression of dissatisfaction about any matter other than an action (as identified within the definition of Appeal)

Quality Improvement (QI) means the result of an effective Quality Improvement System.

Quality Improvement Projects (QIPs) means studies selected by Medi-Cal Managed Care Plans, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a 24-month time frame.

Quality Improvement System (QIS) means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and Contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Indicators means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

Rural Health Clinic (RHC) means an entity defined in 22 CCR 51115.5.

Safety-Net Provider means a provider of comprehensive primary care and/or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health

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centers; rural and Indian Health Service Facilities; disproportionate share hospitals; and, public, university, rural, and children's hospitals.

Seniors and Persons with Disabilities (SPD) means Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary).

Sensitive Services means those services related to:

A. Family Planning
B. Sexually Transmitted Disease (STD)
C. Human Immunodeficiency Virus testing

Service Area means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.

Service Authorization Request means a Member's request for the provision of a Covered Service.

Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

Skilled Nursing Facility (SNF) means, as defined in 22 CCR 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing Facility".

Specialty Care Center means a center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Specialty Mental Health Provider means a 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.

Specialty Mental Health Service means:

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Exhibit E, Attachment 1
DEFINITIONS

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and 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.

Standing Referral means a referral by a Primary Care Physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

State means the State of California.

State Supported Services means those services that are provided under a different contract between the Contractor and the Department.

Subacute Care means, as defined in 22 CCR 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

Subcontract means a written agreement entered into by the Contractor with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS under the terms of this Contract.

Sub-Subcontractor means any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

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Exhibit E, Attachment 1
DEFINITIONS

Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

Targeted Case Management (TCM) means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

Third Party Tort Liability (TPTL) means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

Traditional Provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through Medi-Cal FFS or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

Vaccines for Children (VFC) Program means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating providers. Providers contracting with the Contractor are eligible to participate in this program.

Working day (s) mean State Calendar (State Appointment Calendar, Standard 101) working day(s).

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, Provision 14 Governing Law, Contractor also agrees to the following:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Provision, Governing Law. Except for Provision 18 Sanctions, and Provision 19 Liquidated Damages Provision, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants judicially implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract that is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment may constitute grounds for termination of this Contract in accordance with the procedures and provisions of Provision 16, Subprovision C Termination - Contractor. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/June 14, 2002, at 42 Code of Federal Regulations, Parts 400, 430, 431, 434, 435, 438, 440 and 447. Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.

D. All final Policy and All Plan Letters issued by MMCD are hereby incorporated into this Contract and shall be complied with by Contractor. All Policy and All Plan Letters issued by MMCD subsequent to the

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effective date of this Contract shall provide clarification of Contractors obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

In the event DHCS determines that there is an inconsistency between this Contract and a Policy or All Plan Letter, the Contract shall prevail.

2. Entire Agreement

This written Contract, any amendments, and all documents incorporated by reference shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract consistent with Exhibit E, Attachment 2, Provision 4.

3. Amendment Process

In addition to Exhibit C, Provision 2 Amendment, Contractor also agrees to the following:

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the Contract. The parties agree that the

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development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place.

DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the DHCS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

5. Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer." DHCS will designate the Contracting Officer. The Contracting Officer, on behalf of DHCS, 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.

Contractor will designate a single administrator, called the "Contractor's Representative." Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 9 Notices. The Contractor's Representative will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative, or authorized representative if applicable, will be empowered to legally bind the Contractor to all agreements reached with the State.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Geographic Managed Care Program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Geographic Managed Care Program resides with the State.

Sole authority to establish or interpret policy and its application related to the above areas will reside with the State.

The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

Contractor shall comply with all applicable requirements specified in Federal and State laws and regulations. No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract will be waived except by written agreement of the parties hereto. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

8. Data Certifications

Contractor shall comply with data certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full

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compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

9. Notices

All notices to be given under this Contract will be in writing and will be deemed to have been given when received by DHCS or the Contractor:

Department of Health Care Services	Contractor Name
Medi-Cal Managed Care Division	Contractor Representative
P.O. Box 997413	Contractor Representative Title
Sacramento, CA 95899-7413	Address
Attn: Contracting Officer	City, State Zip

10. Term

A. The Contract will become effective _____, 20XX, and will continue in full force and effect through _____, 20XX subject to the provisions of Provision 13 Termination, Exhibit B, Provision 1 Budget Contingency Clause and Exhibit D, Provision 9, Federal Contract Funds.

B. The term of the Contract consists of the following three periods: 1) The Implementation Period shall extend from the effective date of this Contract which ended as of the effective date of this Contract; 2) The Operations Period shall commence at the conclusion of the Implementation Period, subject to DHCS acceptance of the Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination provisions of Provision 14 Termination, and Provision 16 Sanctions, and subject to the limitation provisions of Exhibit B, Provision 1 Budget Contingency Clause and Exhibit D; and 3) The Phaseout Period shall extend for six (6) months from the end of the Operations Period.

C. If Contractor has begun Operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The Term of the Operations Period is subject to the termination provisions of Provision 14, Termination, and Provision 16, Sanctions, below and subject to the limitation provisions of Exhibit B, Provision 1, Budget Contingency Clause. The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to Provision 13, Contract Extension, below, in which case the Phaseout Period shall apply to the six (6) month period beginning with the first day after the end of the Operations Period, as extended.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

11. Service Area

The Service Area covered under this Contract includes:

<County>

12. Contract Extension

DHCS will have the exclusive option to extend the term of the Contract during the last twelve months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHCS may invoke up to three (3) separate extensions of up to twelve months each. The Contractor will be given at least nine (9) months prior written notice of DHCS' decision on whether or not it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the extension within five (5) working days of the receipt of the notice from DHCS.

13. Termination

In addition to Exhibit C, Provision 7 Termination for Cause, Contractor also agrees to the following:

A. Termination Without Cause - State or Director

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State. Notification shall be given at least 6 months prior to the effective date of termination.

B. Termination for Cause - State or Director

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code Section 14304(a) and 22 CCR 53352.

2) DHCS shall terminate this Contract in the event that: (1) DHHS determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act (42 USC 1396 et. seq.), or (2) the Department of Managed Health Care (DMHC) finds that the Contractor no longer

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qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code § 1340 et seq.) by giving written notice to the Contractor.

3) In cases where DHCS determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B, item 3) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 17, Disputes. Termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides Contractor with at least 60 calendar days' notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days notice is reasonable. Termination under this section does not relieve Contractor of its obligations under Provision 14 Phaseout Requirements below. Phaseout Requirements shall be performed after Contract termination.

C. Termination Without Cause – Contractor

1) Contractor may terminate this Contract without cause by giving written notice of termination to DHCS at least six (6) months prior to the effective date of the termination.

2) Contractor may terminate this Contract if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract. Such termination shall not take effect more than 6 months after DHCS has made its determination that Contractor cannot remain financially solvent through the term of the Contract.

At the same time and along with Contractor's written notice of termination, Contractor shall submit a complete and detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor

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shall submit or otherwise make conveniently and timely available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis. Failure by Contractor to provide a complete and detailed financial analysis with Contractor's termination notice or Contractor's failure to timely provide any additional requested financial information may extend Contractor's requested date of termination. Termination by Contractor pursuant to this Provision shall not relieve Contractor from performing the Phaseout Requirements set forth in Provision 14.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

E. Notice to Members of Transfer of Care

At least 90 calendar days prior to termination or expiration of this Contract, Contractor will notify Members of Contractor's withdrawal from the Medi-Cal Geographic Managed Care Program's Service Area covered by this Contract. At least 60 calendar days prior to the termination or expiration of this Contract, DHCS will notify Members about their medical benefits and available options.

14. Phaseout Requirements

A. DHCS shall retain the lesser of an amount equal to 10% of the last month's Service Area capitation payment or $1,000,000 for the Service Area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the last month of the Operations Period for the Service Area until all activities required during the Phaseout Period for the Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all Phaseout activities for the Service Area are completed by the end of the Phaseout Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout Period for the Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

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PROGRAM TERMS AND CONDITIONS

B. The objective of the Phaseout Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to DHCS or to a successor Contractor, if applicable. The Contractor shall not provide services to Members during the Phaseout Period.

Ninety calendar days prior to termination or expiration of this Contract and through the Phaseout Period for the Service Area, the Contractor shall assist DHCS in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for the Contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to DHCS all reports required under this Contract for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

D. Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable items.

15. Sanctions

Contractor is subject to sanctions and civil penalties taken pursuant to W& I Code Section 14304 and 22 CCR 53872, however, such sanctions and civil penalties may not exceed the amounts allowable pursuant to 42 CFR 438.704. If required by DHCS, Contractor shall ensure subcontractors cease specified

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until DHCS determines that Contractor is again in compliance.

A. In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, DHCS may impose sanctions provided in Welfare and Institutions Code Section 14304 and 22 CCR 53872 as modified for purposes of this Contract. 22 CCR 53872 is so modified as follows:

1) Subsection (b)(1) is modified by replacing “Article 2” with “Article 6”

2) Subsection (b)(2) is modified by replacing “Article 3” with “Article 7”

B. Sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).

C. For purposes of Sanctions, good cause includes, but is not limited to, the following:

1) Three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.

2) In the case of Exhibit A, Attachment 4, the Contractor consistently fails to achieve the minimum performance levels, or receives a “Not Reported” designation on an External Accountability Set measure, after implementation of Corrective Actions.

3) A substantial failure to provide medically necessary services required under this Contract or law to a Member.

4) Non-compliance with the Contract or applicable Federal and State law or regulation.

5) Contractor has accrued claims that have not or will not be recompensed.

D. Sanctions in the form of denial of payments provided for under the Contract for new enrollees shall be taken, when and for as long as, payment for those enrollees is denied by DHHS under 42 CFR 438.730.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:

1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and State law or regulation. Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.

2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;

3) Require Contractor to temporarily suspend or terminate personnel or subcontractors.

4) Take other appropriate action as determined necessary by DHCS.

16. Liquidated Damages Provisions

A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and State law or regulation. Therefore, it is agreed by the State and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result;

a) Proving such damages shall be costly, difficult, and time-consuming;

b) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements;

c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

d) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

e) DHCS may, at its discretion, offset liquidated damages from capitation payments owed to Contractor;

2) Imposition of liquidated damages as specified in Subprovisions B Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, and C Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, shall follow the administrative processes described below;

3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by federal and State law or regulation, not provided or performed;

4) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within 5 working days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay; and the proposed date of the submission of the requirement.

5) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHCS may impose liquidated damages for the amount specified in Subprovision B Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.

6) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within 5 calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, DHCS may impose liquidated damages

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for each day the specified Contractor's requirement is not performed or provided for the amount specified in Subprovision C Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

7) During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, DHCS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in Subprovision C Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this Provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period

DHCS may impose liquidated damages of $25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in Provision 13 Term above.

If DHCS determines that a delay or other non-performance was caused in part by the State, DHCS will reduce the liquidated damages proportionately.

C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period shall at a minimum include:

1) Site Reviews

DHCS may impose liquidated damages of $2,500 per day for each violation of contract requirement not performed in accordance with Exhibit A, Attachment 4 – Quality Improvement System, Provision 10 Site Review, item D Corrective Actions, until the Contract requirement is performed or provided.

2) Third-Party Tort Liability

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

DHCS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with Exhibit E, Attachment 2, Provision 25 Third-Party Tort Liability.

3) Plan Physician Availability

DHCS may impose liquidated damages of $3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, Provider Network, Provision 9 Plan Physician Availability.

4) Contractual Requirements

DHCS may impose liquidated damages not to exceed $10,000 per violation of this Contract's requirements, as well Federal and State law or regulation.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by DHCS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other contract compliance problems.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

17. Disputes

This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute will not preclude DHCS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.

A. Disputes Resolution by Negotiation

DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

Within 15 calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:

1) That it is a dispute pursuant to this section.

2) The date, nature, and circumstances of the conduct which is subject of the dispute.

3) The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

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4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

5) The reason the Contractor is disputing the conduct.

6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.

7) The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer, shall either:

1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

   a) Countermand the earlier conduct which caused Contractor to file a dispute; or

   b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment

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provisions contained in Exhibit B Budget Detail and Payment Provisions, direct DHCS to comply with that Exhibit.

Or,

2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below.

A copy of the decision shall be served on Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph F. Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Provision 18, Disputes, prior to initiating any other action to enforce this Contract.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

E. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851 (d) and proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an appeal under Paragraph D. Appeal of Contracting Officer’s or Alternate Dispute Officer’s Decision above, the Contracting Officer’s or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to Paragraph D. shall be retroactive to the date of the Contracting Officer’s or alternate dispute officer’s decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer’s or alternate dispute officer’s decision or any appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 18. Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

18. Audit

In addition to Exhibit C, Provision 4 Audit, Contractor also agrees to the following:

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this Contract. These books and records will 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 persons eligible to receive Covered Services, the manner in which the Contractor administered its daily business, and the cost thereof.

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHCS; financial records; all Medical Records, medical charts and prescription files; and

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other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, these books and records will be maintained for a minimum of 5 years from the end of the current Fiscal Year in which the date of service occurred, unless a longer period is required by law; in which the record or data was created or applied; and for which the financial record was created or the Contract is terminated, or, in the event the Contractor has been duly notified that DHCS, DHHS, Department of Justice (DOJ), 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.

19. Inspection Rights

In addition to Exhibit D (F), Provision 8 Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 18 Audit, Subprovision B Records Retention, Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, DOJ, Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor and subcontractors pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20 Audit, Subprovision B Records Retention, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

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Exhibit E, Attachment 2
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A. Facility Inspections

DHCS shall conduct unannounced validation reviews of the Contractor's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements.

B. Access Requirements and State's Right To Monitor

Authorized State and Federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, subcontractor, and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during the Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the subcontractor(s).

20. Confidentiality of Member Information

In addition to Exhibit D (F), Provision 13 Confidentiality of Information and Exhibit G Health Insurance Portability and Accountability Act (HIPAA), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted

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thereto. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and (4) will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Contractor by DHCS for this purpose.

21. Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a Contract amendment, in accordance with Exhibit E, Attachment 2, Provision 4.

22. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek

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Exhibit E, Attachment 2
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Post-Payment Recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor retains all OHCS monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

D. Cost Avoidance

1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1) If Contractor reimburses the provider on a FFS basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the OHCS:

a) For services provided to Members with OHC codes A, M, X, Y, or Z;

b) For services defined by DHCS as prenatal or preventive pediatric services; or

c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.

2) In instances where Contractor does not reimburse the provider on a FFS basis, Contractor shall pay for services provided to a Member

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whose eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the OHCS for the cost of actual services rendered.

3) Contractor shall also bill the OHCS for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Reporting Requirements

1) Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A and Part B. Reports shall be made available upon DHCS request.

2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within 10 calendar days of discovery in automated format as prescribed by DHCS. This information shall be sent to the Department of Health Care Services, Third Party Liability Branch, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.

3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

23. Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability Branch

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within 10 calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

B. Information to be delivered shall contain the following data items:

1) Member name

2) Full 14 digit Medi-Cal number

3) Social Security Number

4) Date of birth

5) Contractor name

6) Provider name (if different from Contractor)

7) Dates of service

8) Diagnosis code and description of illness/injury

9) Procedure code and/or description of services rendered

10) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable)

11) Amount paid by other health insurance to Contractor or subcontractor (if applicable)

12) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable)

13) Date of denial and reasons for denial of claims (if applicable)

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14) Date of death (if applicable)

C. Contractor shall notify DHCS' Third Party Liability Branch in writing, the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to Third Party Liability Branch with the information contained in Subprovision B above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to Department of Health Care Services, Third Party Liability Branch, Recovery Section, P.O. Box 2471, Sacramento, CA 95812-2471.

24. Records Related to Recovery for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its subcontractors related to this Contract or subcontracts entered into under this Contract.

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

B. Payment for Records

In addition to the payments provided for in Exhibit B Payment provisions, DHCS agrees to pay Contractor for complying with Subprovision A, Records, above, as follows:

1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Subprovision A. Any third party assisting Contractor with compliance with Subprovision A above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Subprovision A, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.

2) If Contractor uses existing personnel and resources to comply with Subprovision A, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

   a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Subprovision A.

   b) Costs for copies of all documentation submitted to DHCS pursuant to Subprovision A, subject to a maximum reimbursement of 10 cents per copied page.

3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this Provision, including, but not limited to, copies of invoices from third parties and payroll records.

25. Fraud and Abuse

A. For purposes of Exhibit E, Attachment 2, Provision 27, the following definitions apply:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W & I. Code §14043.1(a).)

Conviction or **Convicted** means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term "convicted" in W & I Code Section 14043.1(f)**.**

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2; W & I Code §14043.1(i).)

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.

2) Contractor shall provide effective training and education for the compliance officer and all employees.

3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.

4) Fraud and Abuse Reporting

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

Contractor shall report to DHCS all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity.

Fraud reports submitted to DHCS must, at a minimum, include:

a) Number of complaints of fraud and abuse submitted that warranted preliminary investigation.
b) For each complaint which warranted a preliminary investigations, supply:
    1) Name and/or SSN or CIN;
    2) Source of complaint;
    3) Type of provider (if applicable);
    4) Nature of complaint;
    5) Approximate dollars involved; and
    6) Legal and administrative disposition of the case.

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a) Email at PIUCases@DHCS.ca.gov;
b) E-fax at (916) 440-5287; or
c) U.S. Mail at:

Department of Health Care Services
Medi-Cal Managed Care Division
Attention: Chief, Program Integrity Unit
P.O. Box 997413, Mail Stop 4417
Sacramento, CA 95899-7413

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: Police report, Health Plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (Patient history chart, Patient profile, Claims detail report), Provider enrollment data, Confirmation of services, list items or services furnished by

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the Provider, Pharmaceutical data from manufactures, wholesalers and retailers and any other pertinent information.

5) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 state working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

C. Federal False Claim Act Compliance

Contractor shall comply with 42 USC 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this Provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

26. Confidential Contract Terms

The terms of this Contract are confidential and may be disclosed by the Contractor or its providers and subcontractors only in accordance with the disclosure time limits set forth in Government Code section 6254(q).

27. Federal Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC §794) Nondiscrimination under Federal grants and programs; 45 CFR 84 Nondiscrimination on the basis of handicap in

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programs or activities receiving Federal financial assistance; 28 CFR 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1973 (regarding education programs and activities); 45 CFR 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

28. No Third-Party Beneficiary – Contract

It is not the intention of DHCS or Contractor that Members occupy the position of intended third-party beneficiaries of the rights, obligations, and benefits under this Contract.

29. Disabled Veteran Business Enterprises (DVBE)

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.

30. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

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Exhibit E, Attachment 3
DUTIES OF THE STATE

1. Payment for Services

DHCS shall pay the appropriate capitation payments set forth in Exhibit B, Budget Detail and Payment Provisions, Provision 4, Capitation Rates, to the Contractor for each eligible Member under this Contract, and ensure that such payments are based on actuarially sound capitation rates as defined in 42 CFR, Section 438.6(c). Payments will be made monthly for the duration of this Contract. Any adjustments for Federally Qualified Health Centers will be made in accordance with W & I Code 14087.325.

2. Medical and Other Reviews

DHCS shall conduct reviews in accordance with W & I Code 14456 and 14457. DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.

3. Enrollment

The parties to this Contract agree that the primary purpose of DHCS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal fee-for-service system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, and the lack of a current valid address for some beneficiaries. The parties' desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of Provision 4. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

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Exhibit E, Attachment 3
DUTIES OF THE STATE

4. Enrollment and Disenrollment Processing

A. For purposes of this entire Provision 4, the following definitions shall apply:

1) Mandatory Plan Beneficiary means:

a) A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in 22 CCR 53906(a), both at the time her/his plan enrollment is processed by the DHCS Enrollment Contractor and by MEDS; or

b) An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory enrollment criteria contained in 22 CCR 53906(a); or

c) An Eligible Beneficiary meeting the criteria of 22 CCR 53906(a), and who subsequently meets the criteria of 22 CCR 53906(a).

2) Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:

a) is eligible to receive Covered Services on a FFS basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, ZIP code or county code changes; or

b) Becomes eligible for enrollment in a managed care plan on a retroactive basis.

B. DHCS Enrollment Obligations

1) DHCS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new Members, DHCS or its enrollment contractor shall enroll or assign Eligible Beneficiaries in Contractor's plan when selected by the Eligible Beneficiary or when the Eligible Beneficiary fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, DHCS will ensure that a

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Exhibit E, Attachment 3
DUTIES OF THE STATE

Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 calendar days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in 22 CCR 53906(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate changes and aid code changes, have been executed. DHCS will use due diligence in making any changes to MEDS and to this Contract. DHCS will provide Contractor a list of Members on a monthly basis.

2) DHCS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in 22 CCR 53906(a) to plans in accordance with 22 CCR 53921.5 and 53922.

3) Notwithstanding any other provision in this Contract, Paragraphs 1) and 2) above shall not apply to:

   a) Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management plan and such plan's contract with DHCS expires, terminates, or is assigned or transferred to Contractor;

   b) Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;

   c) Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract;

   d) Eligible Beneficiaries meeting the criteria of 22 CCR 53906(a), who subsequently meet the criteria of 22 CCR 53906(a) due solely to DHCS designating a prior voluntary aid code as a new mandatory aid code;

   e) Eligible Beneficiaries residing in an excluded zip code area within a County that is not a fully Converted County; or

   f) Eligible Beneficiaries without a current valid deliverable address or with an address designated as a County post office box for homeless beneficiaries.

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Exhibit E, Attachment 3
DUTIES OF THE STATE

C. Enrollment Competition

Notwithstanding any provision in this Contract, Contractor understands that Eligible Beneficiaries have a choice of competing health plans in the Sacramento Geographic Managed Care program. Contractor agrees that the State has made no representations or guarantees relating to the number of Eligible Beneficiaries who may choose or be enrolled in Contractor. Contractor specifically agrees that the State shall not be liable for any lack of Eligible Beneficiary Enrollment in Contractor's plan.

D. Disenrollment Processing

DHCS, or its Enrollment Contractor shall review and process requests for Disenrollment and notify the Contractor and the Member of its decision.

5. Approval Process for Submitted Materials During Operations

For materials required to be submitted during the Operations Period of this Contract, DHCS shall make all reasonable efforts to review such materials within 60 calendar days of receipt. At the conclusion of the review, DHCS will notify Contractor whether the materials are approved or why the materials are not approved.

If DHCS does not complete its review of submitted material within 60 calendar days of receipt, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This Provision shall not apply to Subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 6, Provision 12, Subprovisions C and D.

6. Risk Limitation

Except as provided in Exhibit B, Provision 12, there will be no risk limitation and Contractor will have full financial liability to provide Medically Necessary Covered Services to Members.

7. Member Notification

DHCS shall notify Members of their health care benefits and options available upon termination or expiration of this Contract.

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Exhibit F
CONTRACTOR'S RELEASE

Instructions to Contractor:

With final invoice(s) submit one (1) original and two (2) copies. The original must bear the original signature of a person authorized to bind the Contractor. The additional copies may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** _____ entered into between the California Department of Health Care Services (DHCS) and the Contractor (identified below), the Contractor does acknowledge that final payment has been requested via **invoice number(s)** _____, in the **amount(s) of $** _____ and **dated** _____
If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, the Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement does not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment, will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a percentage (0% to 100%) of the materials, goods, supplies or products offered or used in the performance of the above referenced contract meets or exceeds the minimum percentage of recycled material, as defined in Public Contract Code Sections 12161 and 12200.

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING TO THE FINAL INVOICE

Contractor's Legal Name (as on contract): _____

Signature of Contractor or Official Designee: _____ Date: _____

Printed Name/Title of Person Signing: _____

DHCS Distribution: Accounting (Original) Program CMU contract file

DHCS 2352 (7/04)

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. Recitals

A. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental condition of an individual, the provision of medical care to an individual, or the past, present, or future payment for the provision of medical care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI shall have the meaning given to such term under the Health Insurance Portability and Accountability Act (HIPAA) and HIPAA regulations, as the same may be amended from time to time.

B. DHCS desires to protect the privacy and provide for the security of PHI disclosed, created or received on behalf of DHCS pursuant to this Contract.

IN THE USE OR DISCLOSURE OF INFORMATION PURSUANT TO THIS CONTRACT, THE PARTIES AGREE AS FOLLOWS:

2. Permitted Uses and Disclosures

A. *Permitted Uses and Disclosures.* Except as otherwise required by law, Contractor may use or disclose PHI pertaining to Members only to perform functions, activities or services specified in this Contract provided that such use or disclosure is for purposes directly connected with the administration of the Medi-Cal program. Those activities which are for purposes directly connected with the administration of the Medi-Cal program include, but are not limited to: establishing eligibility and methods of reimbursement; determining the amount of medical assistance; providing services for Members; conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Medi-Cal program; and conducting or assisting a legislative investigation or audit related to the administration of the Medi-Cal program.

B. *Specific Use and Disclosure Provisions.* Except as otherwise indicated in this Contract, Contractor may:

1) *Use and disclose for management and administration.* Use and disclose PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of the

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Contractor, provided that disclosures are required by law, or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

2) *Provision of Data Aggregation Services.* Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Contractor on behalf of DHCS with PHI received by the Contractor in its capacity as the Contractor of another covered entity, to permit data analyses that relate to the medical care operations of DHCS.

C. *Prohibition of External Disclosures of Lists of Members.* A Contractor must provide DHCS' Contracting Officer with a list of external entities, including persons, organizations, and agencies, other than those within its treatment network and other than DHCS, to which it discloses lists of Medi-Cal Member names and addresses. This list must be provided within 30 calendar days of the execution of this Contract and annually thereafter.

3. Responsibilities of Contractor

Contractor agrees:

A. *Divulging Medi-Cal Status.* Not to divulge the Medi-Cal status of a Contractor's Members without DHCS' prior approval except for treatment, payment and operations, or as required by law.

B. *Safeguards.* To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract. Contractor shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. Contractor will provide DHCS with information concerning such safeguards as DHCS may reasonably request.

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C. *Security.* To take any and all appropriate steps necessary to ensure the continuous security of all computerized data systems containing PHI, and provide data security procedures for the use of DHCS at the end of the Contract period. These steps shall include at a minimum:

1) Complying with all of the data system security safeguards listed in this Contract;

2) Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR 160 and 164), as necessary in conducting operations on behalf of DHCS under this Contract;

3) General Security Controls

a) Confidentiality Statement. All persons that will be working with DHCS PHI must sign a confidentiality statement supplied by the Contractor. The statement must include at a minimum, General Use, Security and Privacy safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI. The statement must be renewed annually.

b) Background check. Before a member of the Contractor's workforce may access DHCS PHI, Contractor must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data.

c) Workstation/Laptop encryption. All workstations and laptops that process and/or store DHCS PHI must be encrypted with a DHCS approved solution or a solution using a vendor product specified on the California Strategic Sourced Initiative (CSSI) located at the following link:

www.pd.dgs.ca.gov/masters/EncryptionSoftware.html

The encryption solution must be full disk unless approved by the DHCS Information Security Office.

d) Only the minimum necessary amount of DHCS PHI may be downloaded to a laptop or hard drive when absolutely necessary for business purposes.

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

e) Removable media devices. All electronic files that contain DHCS PHI must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.) with a DHCS approved solution or a solution using a vendor product specified on the CSSI.

f) Email security. All emails that include DHCS PHI must be sent in an encrypted method using a DHCS approved solution or a solution using a vendor product specified on the CSSI.

g) Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

h) Patch Management. All workstations, laptops and other systems that process and/or store DHCS data must have security patches applied and up to date.

i) User ID's and Password Controls. All users must be issued a unique user name for accessing DHCS PHI. Passwords are not to be shared. Must be at least eight characters. Must be a non-dictionary word. Must not be stored in readable format on the computer. Must be changed every 60 days. Must be changed if revealed or compromised. Must be composed of characters from at least three of the following four groups from the standard keyboard:

   i. Upper case letters (A-Z)
   ii. Lower case letters (a-z)
   iii. Arabic numerals (0-9)
   iv. Non-alphanumeric characters (punctuation symbols)

j) Data Destruction. All DHCS data must be destroyed using Department of Defense methods for data destruction when the DHCS data is no longer needed.

k) Remote Access. Any remote access to DHCS PHI must be executed over an encrypted method approved by DHCS or using a vendor product specified on the CSSI. All remote access must be limited to minimum necessary and least privilege principles.

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

4) System Security Controls

a) System Timeout. The system must provide an automatic timeout after no more than 20 minutes of inactivity.

b) Warning Banners. All systems containing DHCS PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. User must be directed to log off the system if they do not agree with these requirements.

c) System Logging. The system must log success and failures of user authentication at all layers. The system must log all system administrator/developer access and changes if the system is processing and/or storing PHI. The system must log all user transactions at the database layer if processing and/or storing DHCS PHI.

d) Access Controls. The system must use role based access controls for all user authentication, enforcing the principle of least privilege.

e) Transmission Encryption. All data transmissions must be encrypted end-to-end using a DHCS approved solution or a solution using a vendor product specified on the CSSI, when transmitting DHCS PHI.

f) Host Based Intrusion Detection. All systems that are accessible via the Internet or store DHCS PHI must actively use a comprehensive third-party real-time host based intrusion detection and prevention program.

5) Audit Controls

a) System Security Review. All systems processing and/or storing DHCS PHI must have at least an annual system security review. Reviews must include administrative and technical vulnerability scanning tools.

b) Log Reviews. All systems processing and/or storing DHCS PHI must have a routine procedure in place to review system logs for unauthorized access. Logs must be maintained for six years after the occurrence.

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c) Change Control. All systems processing and/or storing DHCS PHI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

6) Business Continuity / Disaster Recovery Controls

a) Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI in the event of an emergency.

b) Data Backup Plan. Contractor must have established documented procedures to backup DHCS data to maintain retrievable exact copies of DHCS PHI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup tapes, the amount of time to restore DHCS data should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

7) Paper Document Controls

a) Supervision of Data. Contract must have a policy that:

(1) DHCS PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information.

(2) DHCS PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

b) Escorting Visitors. Visitors to areas where DHCS PHI is contained shall be escorted and DHCS PHI shall be kept out of sight while visitors are in the area unless they are authorized to view the PHI.

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i. Confidential Destruction: DHCS PHI must be disposed of through confidential means, such as shredding and pulverizing.

ii. Removal of Data. DHCS PHI must not be removed from the premises of the Contractor except for the routine business purposes or with the express written permission of DHCS.

iii. Faxing. Faxes containing DHCS PHI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.

iv. Mailing. DHCS PHI shall only be mailed using secure methods. Large volume mailings of DHCS PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted.

D. *Contractor's Agents.* To ensure that any agents, including subcontractors but excluding providers of treatment services, to whom Contractor provides PHI received from or created or received by Contractor on behalf of DHCS, agree to the same restrictions and conditions that apply to Contractor with respect to such PHI; and to incorporate, when applicable, the relevant provisions of this Contract into each subcontract or subaward to such agents or subcontractors.

E. *Availability of Information to Members.* To provide access to members (upon reasonable notice and during Contractor's normal business hours) to their PHI in a Designated Record Set in accordance with 45 CFR 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical and billing records about Members; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about Members on behalf of DHCS.

F. *Internal Practices.* To make Contractor's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Contractor on behalf of DHCS, available to DHCS

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in a time and manner designated by DHCS, for purposes of determining compliance with the provisions of this Contract.

G. *Documentation and Accounting of Disclosures.* To document and make available to DHCS and to a Member such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Member for an accounting of disclosures of PHI, in accordance with 45 CFR 164.528.

H. *Notification of Breach.* During the term of this Contract:

1) *Discovery of Breach.* To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract. Notification shall be provided to the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notification shall be provided by calling the DHCS ITSD Help Desk. Contractor shall take:

a) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment and

b) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2) *Investigation of Breach.* To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the SDHCS Privacy Officer, and the DHCS Information Security Officer of:

a) What data elements were involved and the extent of the data involved in the breach,

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b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data,

c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,

d) A description of the probable causes of the improper use or disclosure; and

e) Whether Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual notifications or breaches are triggered.

3) ***DHCS Contact Information****.* To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Contract.

DHCS MMCD Contracting Officer	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See Provision 3 of Exhibit A (Scope of Work) for DHCS MMCD **Contracting Officer** information	Privacy Officer c/o Office of Legal Services California Department of Health Care Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Telephone: (916) 440-7750 Email: privacyofficer@DHCS.ca.gov	Information Security Officer Information Security Office P.O. Box 997413, MS 6302 Sacramento, CA 95899-7413 Email: DHCSiso@DHCS.ca.gov Telephone: ITSD Help Desk 916-440-7000 or 800-579-0874

I. *Notice of Privacy Practices.* To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit. Such NPP's must include the DHCS Privacy Officer contact information included in part H. above of this Contract as an alternative means for Medi-Cal beneficiaries to lodge privacy complaints. All NPP's created or modified after August 1, 2003, must be submitted to Contractor's DHCS Contracting Officer for review.

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4. Miscellaneous Provisions

A. *Amendment.* The parties acknowledge that Federal and State laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS's request, Contractor agrees to promptly enter into negotiations with DHCS concerning an amendment to this Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA regulations or other applicable laws. DHCS may terminate this Contract upon 30 calendar days written notice in the event (i) Contractor does not promptly enter into negotiations to amend this Contract when requested by DHCS pursuant to this Section or (ii) Contractor does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA regulations, and applicable laws.

B. *Assistance in Litigation or Administrative Proceedings.* Contractor shall make itself and its employees, and use all due diligence to make any subcontractors or agents assisting Contractor in the performance of its obligations under this Contract, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where Contractor or its subcontractor, employee or agent is a named adverse party.

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